**Suspected Lower GI Cancer Referral Form**

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| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS Number: | |
| Telephone Numbers  **Please check tel no's with patient** | Tel No (Home): | Tel No (work): | Tel No (Mobile): |
| **GP Details** | | | |
| Referring GP: | | GP Tel No: | |
| Practice Name: | | Practice Email Address: | |
| Practice Address: | | Date of decision to refer: | |

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| **Patient Information** | | | |
| Does your patient have a learning disability? | | | YesNo |
| Is your patient able to give informed consent? | | | YesNo |
| Is your patient fit for day case investigation? | | | YesNo |
| If a translator is required, please specify language: | | | |
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| Is patient on any of the following medications? | | | |
| Aspirin | YesNo | Indication for therapy: | |
| Clopidogrel /Prasugrel etc . | Yes  No | Indication for therapy: | |
| Warfarin | Yes No | Indication for therapy: | |
| NOAC (Rivaroxaban etc.) | Yes No | Indication for therapy: | |
| Insulin | Yes  No | Type 1  Type 2 | |

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| It would be helpful if you could provide performance status information (please tick as appropriate)  Fully active  Able to carry out light work  Up & about 50% of waking time  Limited to self-care, confined to bed/chair 50%  No self-care, confined to bed/chair 100% |

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| Please confirm that the patient is aware that this is a suspected cancer referral:  Yes  No |
| Date(s) that patient is unable to attend within the next two weeks:  *If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

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| **Reasons for Referral** |
| **All patients should meet NICE guidelines for suspected cancer 2015.**  **All patients should have had a FIT result received prior to referral.**  **Please detail your reason for referring, presenting symptoms and your examination findings OR attach a referral letter containing these details.** |
| **Referral Criteria** |
| **All referrals for suspected lower GI cancer except those for anal mass or ulceration must be accompanied by the result of a Faecal Immunochemical Test (FIT).**  **If referring with Iron Deficiency Anaemia, it is essential to provide a recent Hb, MCV and Ferritin in addition to a Coeliac Screen performed within the last two years.** |
| MERGE FIELD  Numeric FIT Value:  Patient unable or unwilling to complete FIT, Please specifiy: |
| **Colorectal cancer**  **Consider referring any adult with a rectal or abdominal (but not pelvic) mass that you suspect could be cancer (No age range in NICE guidance)**  ***Any adult with a positive FIT test.***  ***Aged*** ***under 50*** with rectal bleeding **and** any of the following unexplained symptoms or findings (consider):  abdominal pain;  change in bowel habit;  weight loss;  iron-deficiency anaemia (*Hb, MCV and ferritin essential*)  ***Aged 40 and over*** with unexplained weight loss and abdominal pain  ***Aged 50 and over*** with unexplained rectal bleeding  ***Aged 60 and over*** with either of:  iron-deficiency anaemia (Hb, MCV, Ferritin essential) ***or***  changes in bowel habit |
| **Anal cancer**  unexplained anal mass or unexplained anal ulceration (consider) |

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| **Clinical Summary** |
| **Clinical History (significant past and current medical history):** |
| **Current medication:** |
| **Blood Tests (if available – last 3 months):** |
| **Allergies:** |
| **Smoking:** |
| **BMI** (if available): |
| **Alcohol** (if available)**:** |

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| **For hospital to complete** UBRN:  Received Date: |