**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?  | [ ]  Yes[ ] No  |
| Is your patient able to give informed consent?  | [ ]  Yes[ ] No  |
| Is your patient fit for day case investigation?  | [ ]  Yes[ ] No  |
| If a translator is required, please specify language:       |
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| Is patient on any of the following medications? |
| Aspirin  | [ ]  Yes[ ] No  | 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:  |