**Suspected Lung Cancer Referral Form**

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

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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:        |
| 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  |  |

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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%Fully active  |

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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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| **Reason for Referral** |
| **All patients should meet NICE guidelines for suspected cancer 2015****Please detail your reasons for referring, presenting symptoms and your examination findings OR attach a referral letter containing these details.**      |

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| **Referral Criteria** |
| **NICE recommends urgent CXR under a variety of circumstances. Please refer to the** [**NG12 guidelines**](https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#lung-and-pleural-cancers) **for further guidance.**Lung cancer or mesothelioma[ ]  has chest X‑ray findings that suggest lung cancer or mesothelioma***Chest X-ray should be no more than 3 weeks old***[ ]  is aged 40 and over with [unexplained](http://www.nice.org.uk/guidance/NG12/chapter/terms-used-in-this-guideline#terms-used-in-this-guideline) haemoptysis***Please arrange a chest X-ray to take place in next 48 hours***For minor or resolved haemoptysis without other symptoms suggestive of lung cancer, consider just a chest X-ray[ ]  has a normal chest X-ray but with a high index of suspicion and /or relevant lymphadenopathy or clubbing |

**Clinical History (significant past and current medical history):**

<Problems(table)>

**Current medication:**

<Repeat Templates(table)>

**Blood Tests (if available – last 3 months):**

<Pathology & Radiology Reports(table)>

**Spirometry (if available – last 12 months):**

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| FEV1 | <Numerics> |
| FVC | <Numerics> |
| FEV1/FVC Ratio | <Numerics> |

**Allergies:**

<Allergies & Sensitivities(table)>

**Smoking:**

<Diagnoses(table)>

**BMI** (if available):

<Latest BMI>

**Alcohol** (if available)**:**

<Numerics(table)>

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