**Non-Specific but Concerning Symptoms Pathway 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: <Your Name> | GP Tel No: <Organisation Details> |
| Practice Name: <Organisation Address>  | Practice Email Address: <Organisation Details> |
| 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:       |
| Metformin | [ ] Yes [ ] No  |  |
| Insulin | [ ] Yes [ ] No  |  |
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| **Radiology Information** |
| Pregnant? | [ ] Yes[ ] No  | Aneurysm Clips? | [ ] Yes[ ] No  |
| Cardiac Pacemaker? | [ ] Yes[ ] No  | Mechanical Heart Valves? | [ ] Yes[ ] No  |
| Intra-orbital metallic foreign body? | [ ] 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% |

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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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| **Indication for referral** |
| This service is for patients who have significant progressive symptoms of recent onset or signs that make the GP suspect a diagnosis of cancer, but where there are no indications to refer the patient via a site-specific cancer (2WW) pathway. Please refer to the [NICE GUIDELINE ON RECOGNITION AND REFERRAL OF SUSPECTED CANCER](https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer) for further information. **This pathway is not intended for the investigation of people with chronic symptoms for whom the GP has a low index of suspicion for cancer.**  |

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| **Pre-referral Criteria** |
| Examination findings |
| **Chest exam normal** | [ ]  | **No regional lymphadenopathy** | [ ]  |
| **Breast exam normal** | [ ]  |  |  |
| **Abdominal, Rectal and Genital exam normal** | [ ]  |  |  |
| **Cutaneous exam normal** | [ ]  |  |  |
| Investigation findings |
| **FBC, LFT, Renal, HBA1c, CRP are included** | [ ]  | **CA125 less than 35** | [ ]  |
| **PSA normal or too low to explain symptoms** | [ ]  | **TFT not abnormal enough to explain symptoms** | [ ]  |
| Special Test findings |  |  |  |
| **FIT test normal**  | [ ]  | **Urinalysis does not indicate urology 2WW referral\*** | [ ]  |
| **PLEASE INSERT FIT VALUE HERE:** |  |

* \* Patients with Non Visible Haematuria and a raised white cell count should be referred via urology 2WW

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| **Primary Reason For Referral / GP Letter** |
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| **In the event that CT Thorax, Abdomen and Pelvis is normal (Tick one box only):** |
| **YES**[ ]  | **I am happy to take back responsibility for ongoing management or investigation of the patient.** | **I would still have significant concerns about this patient.** | **YES**[ ]  |
| **Clinical Summary** |
| **Clinical History (significant past and current medical history):**      <Summary(table)> |
| **Has the patient had a previous cancer diagnosis?**       [ ]  **YES**[ ]  **NO****If yes – which cancer site?** |
| **Current medication:** <Medication(table)> |
| **Repeat medication:**<Medication(table)> |
| **eGFR** <Numerics> |
| **Blood Tests (if available – last 3 months):**      <Pathology & Radiology Reports(table)> |
| **Allergies:** <Allergies & Sensitivities> |
| **Smoking:** <Diagnoses(table)> |
| **BMI** (if available):<Latest BMI> |
| **Alcohol** (if available)**:**<Numerics> |

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| Please send this NSCS Cancer referral to the appropriate Provider for your area using their preferred method |
| Torbay and South Devon NHS Foundation Trust | e-Referral Service |
| University Hospitals Plymouth NHS Trust  | e-Referral Service |
| Royal Devon & Exeter NHS Foundation Trust  | e-Referral Service |
| Northern Devon Healthcare NHS Trust | e-Referral Service |

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