**Non-Specific but Concerning Symptoms Pathway Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS Number: | |
| Telephone Numbers  **Please check tel nos 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: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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: | | | |
| 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: | |
| Metformin | Yes No |  | |
| Insulin | Yes No |  | |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Radiology Information** | | | |
| Pregnant? | YesNo | Aneurysm Clips? | YesNo |
| Cardiac Pacemaker? | YesNo | Mechanical Heart Valves? | YesNo |
| Intra-orbital metallic foreign body? | YesNo |  |  |

|  |
| --- |
| 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% |

|  |
| --- |
| 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.* |

|  |
| --- |
| **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.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Reason For Referral / GP Letter** | | | |
|  | | | |
| **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):** | | | |
| **Has the patient had a previous cancer diagnosis?**  **YES**  **NO**  **If yes – which cancer site?** | | | |
| **Current medication:** | | | |
| **Repeat medication:** | | | |
| **eGFR** | | | |
| **Blood Tests (if available – last 3 months):** | | | |
| **Allergies:** | | | |
| **Smoking:** | | | |
| **BMI** (if available): | | | |
| **Alcohol** (if available)**:** | | | |

**\*\*\*\*\*\* INSERT MERGE FIELDS FOR eGFR, Medication, Allergies, bloods, smoking, BMI, alcohol \*\*\*\*\*\*\***

|  |  |
| --- | --- |
| 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 |

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