**Suspected Sarcoma Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **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: <Sender Name> | | GP Tel No: <Organisation Details> | |
| Practice Name: <Organisation Details> | | Practice Email Address: | |
| Practice Address:  <Organisation 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:  Drug, indication, target INR, stability of INR | |
| NOAC (Rivaroxaban etc.) | Yes No | Indication for therapy: | |
| Insulin | Yes No |  | |

|  |
| --- |
| 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 |

|  |
| --- |
| Please confirm that the patient is aware that this is a suspected cancer referral:  YesNo |
| 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.* |

|  |
| --- |
| **Level of Cancer Concern** (completion optional) |
| **All patients should meet NICE guidelines for suspected cancer 2015**  *“I’m very concerned that my patient has cancer”*  *“I’m unsure, it might well be cancer but there are other equally plausible explanations.”*  *“I don’t think it likely that my patient has cancer but they meet the guidelines.”*  **Reasons for referring**  *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* |

|  |
| --- |
| **Referral Criteria** |
| Bone Sarcoma  X‑ray suggests the possibility of bone sarcoma (please include x-ray results) |
| Soft Tissue Sarcoma  Unexplained lump increasing in size (will be triaged direct for ultrasound if appropriate)  Ultrasound findings of sarcoma or findings are uncertain and clinical concern persists  Location of Mass |
| **The following recent blood results, less than 8 weeks old, would be extremely helpful:**  FBC, eGFR, U&Es |

|  |
| --- |
| **Clinical Summary** |

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

<Summary(table)>

**Current Medication:**

<Medication(table)>

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

<Pathology & Radiology Reports(table)>

**Allergies:**

<Allergies & Sensitivities(table)>

**Smoking**: <Diagnoses>

**BMI** (if available): <Latest BMI>

**Alcohol** (if available) <Numerics>

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