**Suspected Sarcoma 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? | | | 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 | 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:  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.* |

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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.**    **To include: Site, Size, Side, Growth rate, presence or absence of pain** |
| **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 or other imaging findings suggest sarcoma OR findings are uncertain and clinical concern persists |
| **The following recent blood results, less than 8 weeks old, would be extremely helpful:**  FBC, eGFR, U&Es |
| **Referral for suspected tumours in children varies according to acute trust. If you are concerned that you have identified a child with a bone or soft tissue tumour, please telephone your local paediatric team for advice on how to arrange timely investigation.** |

**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)>

**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: |