**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: <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> |

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

|  |
| --- |
| 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: [ ]  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.* |

|  |
| --- |
| **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)>

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