**Suspected Upper Gastrointestinal Tract Cancers 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: <Sender Name> | GP Tel No: <Organisation Details> |
| Practice Name: <Organisation Details> | Practice Email Address:       |
| Practice Address: <Organisation Address> | Date of decision to refer:       |

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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:       |
| 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% |

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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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| **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** |
| **Oesophageal or gastric cancer**[ ]  Upper GI endoscopy indicates **oesophageal cancer.** [ ]  Aged 55 and over with weight loss and any of the following\*[ ]  Upper abdominal pain\*[ ]  Reflux\*[ ]  dyspepsia \*[ ]  dysphagia\*[ ] upper abdominal mass consistent with stomach cancer\* | **\*Northern Devon Healthcare Trust Only:****Please use direct access 2ww OGD form unless necessary to see in clinic first** |
| **Gall bladder cancer**[ ]  ultrasound indicates gall bladder cancer |
| **Liver cancer**[ ]  ultrasound indicates liver cancer |
| **Pancreatic cancer**[ ] aged 40 and over and have jaundice;[ ]  CT indicates pancreatic cancer;[ ]  ultrasound indicates pancreatic cancer. |
| **The following recent blood results, less than 8 weeks old, would be extremely helpful:**FBC, U&E, LFT, Ferritin, Iron studies, bilirubin. |
| **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>

**PLYMOUTH HOSPITALS ONLY**

Consider **urgent referral** for patients without dyspepsia but with any of the following:

Persistent nausea, vomiting/weight loss

Iron Deficiency Anaemia (please use 2ww Colorectal form).

Please use [fast track jaundice](https://www.plymouthhospitals.nhs.uk/download.cfm?doc=docm93jijm4n711.doc&ver=863) if appropriate. Please indicate if the patient uses insulin.

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| Please send this Suspected Upper GI Cancer referral to the appropriate Provider for your area using their preferred method |
| Plymouth Hospitals Trust  | e-Referral Service |
| Royal Devon & Exeter NHS Foundation Trust  | email Rde-tr.endoscopy@nhs.net |
| Northern Devon Healthcare NHS Trust | e-Referral Service |

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