**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: <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?  | [ ]  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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| **Reason for Referral** |
| **All patients should meet NICE guidelines for suspected cancer 2015****Reasons for referring** *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* |

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| **Direct Access Imaging Criteria** |
| NICE recommends **Direct Access CT** to be performed **within 2 weeks (or ultrasound if not available) to** investigate Ca Pancreas inpatients with **weight loss and any of** the following**:** |
| Diarrhoea [ ] back pain [ ]  | Abdominal pain [ ] Nausea or vomiting [ ]  | Constipation [ ] New‑onset diabetes [ ]  |
| **2WW Referral Criteria** |
| **Oesophageal or gastric 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\* | **NDHT GPs can access 2WW direct access OGD** [NDHT Open Access Upper GI endoscopy referral form](https://www.northdevonhealth.nhs.uk/wp-content/uploads/2014/06/Open-access-Upper-GI-endoscopy-referral-form-Dec-15.doc)**intended for patients who are suitable for straight to test** |
| **SD&T GPs can access a 4WW OGD Pathway for low-risk-but-not-no-risk symptoms available** [SDT\_UpperGI\_Non-2WW\_Form-V1.0](https://southwest.devonformularyguidance.nhs.uk/documents/Referral-documents/Referral-forms/SDT-Upper-Gi-Non-2ww-Form-V1.0.docx) |
| **Plymouth GPs can access the fast track jaundice service** [Fast-track Jaundice Clinic - UHP referral](https://southwest.devonformularyguidance.nhs.uk/documents/Referral-documents/Referral-forms/Plymouth-Fast-Track-Jaundice-docx.docx) |
| **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 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:**

<Allergies & Sensitivities(table)>

**BMI** (if available):

<Latest BMI>

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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:  |