**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? | | | 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: | |
| 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](mailto:Rde-tr.endoscopy@nhs.net) |
| Northern Devon Healthcare NHS Trust | e-Referral Service |

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