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**URGENT REFERRAL FOR POSSIBLE GYNAECOLOGICAL CANCER**

**(INCLUDING PMB / PELVIC MASS REFERRAL)**

**If you wish to include an accompanying letter, please do so.**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

**Preferred appointment location:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Alexandra Hospital |  | Worcestershire Royal Hospital |  | Kidderminster Hospital |  | Evesham Community Hospital |  |

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| --- | --- |
| **Patient Details** Surname Forename D.O.B. Gender Address Postcode Home telephone no: Mobile no: NHS No Interpreter required? Yes/No (Delete as applicable)If yes, state language …………………………………………….Does the patient have a disability? Yes/No (Delete as applicable) If yes, please state………………………………………………… | **GP Details (inc Fax Number)** |
| Date of Decision to Refer **Date Referral Faxed**  GP Signature |
| **\*\* PLEASE SELECT ONE REFERRAL PATHWAY ONLY – DO NOT TICK BOTH SIDES \*\*** |
| **PMB / PELVIC MASS REFERRAL:****(Patient will have urgent USS +/- Gynae clinic review)****Fax number: 01527 512005****Tel number: 01527 512099** | **TWO WEEK WAIT REFERRAL****– HIGH SUSPICION OF GYNAECOLOGICAL CANCER:****(Patient will be seen in Gynae clinic with 2 weeks)****Cancer referral centre fax: 01562 754312 or e-referral** |
| **Requests for an U/S scan on this pathway can be made on ICE**More than one or a single heavy episode of post-menopausal bleeding (PMB) in women **not**on HRTHas the patient had a hysterectomy? Y / N**(if yes, specify below)**Is patient post-menopausal? Y / NHRT – unexpected or prolonged bleeding occurring after 6 months of starting HRTPalpable pelvic mass not obviously fibroids | **CANCER TYPE SUSPECTED (tick relevant box):**Ovary (suspicious scan findings/ Ca125):**(please send results of Ca125 + CEA with referral)**Endometrium (suspicious examination findings orbiopsy result):Cervix (suspicious lesion on examination):Vagina / vulva (suspicious lesion on examination): |
| **Clinical Details/Examination:………………………………………………………………………………………………………….****………………………………………………………………………………………………………………………………………………****………………………………………………………………………………………………………………………………………………****TYPE OF EXAMINATION CONDUCTED(essential): HAS PATIENT BEEN INFORMED POSSIBILITY** **OF MALIGNANCY?****Abdominal: Bi-manual: Speculum: YES NO** **(tick Yes) (tick Yes) (tick Yes)** |
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For 2ww office use only:

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| Date Fax Received: |  | Appointment Date/Time/Site/Consultant: |  |

Revised Oct 2012