**wahncola25**

**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:**

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| 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 HRT  Has the patient had a hysterectomy? Y / N  **(if yes, specify below)**  Is patient post-menopausal? Y / N  HRT – unexpected or prolonged bleeding  occurring after 6 months of starting HRT  Palpable 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 or  biopsy 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