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| **Patient Details:**  **Surname: Forename:**  **DoB: Gender:**  **Ethnicity:**  **Address:**  **Hospital/NHS number:**  **Landline number:**  **Mobile number:**  **(The patient consents to be contacted by text on the above mobile? Yes No )**  **Interpreter required? Y/N First Language:**  **Patient has capacity to consent? Y/N** | **Registered GP Details:**  **Fax no:**  **Telephone:**  **Email:** |
| **Date of Decision to refer:** |
| **Date of referral:** |
| **Name of referring GP:**  **GP Signature:** |

**GP Declaration:**

* I have informed the patient they have symptoms which may be caused by cancer, that they are being referred to the rapid access suspected cancer pathway and that they may require further investigation which may include bowel preparation.
* I am confirmed that the patient is willing and available to attend for investigations within the next 2 weeks
* I have provided the patient with the Urgent Suspected Cancer Referral Information Leaflet



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| ***FIT POSITIVE PATHWAY – URGENT SUSPECTED CANCER REFERRAL***  *Patients* ***MUST*** *be aged 40 years or over with a positive FIT (≥10 ugHB/g) result and have one or more of the following:* | | | ***Please include FIT value*** |
| ***1.*** | *Rectal bleeding with 2 or more episodes in a ≥ 4 week period* | | *FIT result:*  *………..* |
| ***2.*** | *Change in bowel habit (looser/more frequent) ≥ 6 weeks* | | *FIT result:*  *………..* |
| ***3.*** | *Unexplained/Unintentional weight loss (> 10% drop in body weight)*  *Please specify: …… kg.* | | *FIT result:*  *…………* |
|  |  |  |  |
| ***ANY ADULT (18 years or over) WITH ANY OF THE FOLLOWING SYMPTOMS (FIT +/-ve) Please refer for FIT test at the same time as the referral - do not wait for the result. An initial face to face appointment may be booked for these patients.*** | | |  |
| ***4.*** | *Unexplained and un-investigated in the last 3 years Iron Deficiency Anaemia (< 110 g/L in men or < 100 g/L in non-menstruating women and ferritin <50ng/ml, negative screen for Coeliac Disease; other major clinical causes of IDA excluded and incomplete or not sustained response to IRT)* | | *Hb……*  *MCV…… Ferritin…….* |
| ***5.*** | *Abdominal Mass.* | |  |
| ***6.*** | *Unexplained rectal mass on examination* | |  |
| ***7.*** | *Anal ulceration/mass on examination* | |  |

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| eGFR Result: | Date of Test: |

PLEASE ENSURE FBC and U&E IS AVAILABLE ON REFERRAL (WITHIN LAST 2-MONTHS) OR REQUESTED (TO BE UNDERTAKEN WITHIN 48-HOURS OF REFERRAL BEING MADE)



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| **ADDITIONAL HISTORY (or attach GP summary with the following details)** | |
| Last Consultation (reason for referral)  Medical Hx  Medications (incl. anticoagulation & antiplatelets)  Allergies | |
| **\* PLEASE COMPLETE FOR ALL REFERRALS:** | |
| \*WHO Performance status (see scale below, please tick one) 0  1  2  3  4 | |
| **WHO Performance Status Scale:** | |
| **WHO Grade** | **Explanation of activity** |
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours |
| 3 | Capable of only limited self-care, confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair |

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| **For 2ww office use only**  Page 1of **2** | | |
| Date referral received | Triage date | Consultant |