**URGENT REFERRAL FORM FOR SUSPECTED UROLOGICAL CANCERS**

**\*INDICATES MANDATORY FIELDS – IF NOT COMPLETED OR NO TO ANY QUESTION REFERRALS MAY NOT BE ACCEPTED**

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| **PATIENT DETAILS** | **GP DETAILS** |
| **Name:** |  | **Name:** |  |
| **Address:** |  |  |  |
|  |  |  |  |
|  |  | **Phone No:** |  |
| **NHS Number:** |  | **Fax No:** |  |
| **Hospital number:** |  | **Name of referrer:** |  |
| **Date of Birth:** |  | **Decision to refer date:** |  |
| **Interpreter/Sign Language required:****Language:** | ☐ Yes ☐ No | **Date of referral if different from above:** |  |
| **Contact No (next 48 hrs):** | **Home:**  |  | **Work:**  |  | **Mobile:** |  |
| **Patient consents to be contacted by text message?:** |  [ ]  Yes [ ]  No |
| **GP Declaration – Please confirm and tick**[ ]  I have informed the patient they have symptoms which may be caused by cancer, that they are being referred urgently, and the nature of the tests likely to take place. [ ]  I have provided the patient with an Urgent Referral Patient Information Leaflet.[ ]  My patient has confirmed they are available to attend within 2 weeks. [ ]  My patient is aware that they will be offered the first available appointment at any one of our hospitals (Queen Elizabeth,  Heartlands, Solihull or Good Hope Hospital). |

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| **REASON FOR REFERRAL**  |
| **Bladder/Renal**  | Unexplained visible haematuria without UTI ≥45 years |  | Visible haematuria persisting/ recurring after UTI treatment ≥45 years |  | Non-visible haematuria + dysuria or ↑WCC ≥ 60 years(If isolated Non-visible haematuria, please do a routine referral) |  |
| **Testis**  | (Swelling in body) Non-painful enlargement or change in shape or texture of the testis  |  |
| **Renal**  | Palpable renal mass  |  | Solid mass in the kidney on imaging  |  |
| **Penile**  | Mass or ulcerated lesion, STI excluded/treated, unexplained or persistent symptoms affecting the foreskin or glans.  |  |

FOR ALL PROSTATE REFERRALS PLEASE ENSURE ALL MANDATORY INFORMATION IS PROVIDED.

**\*INDICATES MANDATORY FIELD – IF NOT COMPLETED REFERRALS WILL NOT BE ACCEPTED.**

**This form is not for the referral of patients with a known prostate cancer diagnosis – please refer urgently to last known consultant**

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| **Prostate**  | \*DRE: Please describe findings . | \* | \* PSA value(s):***(for a PSA value less than 10 please repeat after 6 weeks and refer if persistently raised)*** | \* |

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| **Age** | **Below 40****years** | **40-49 years** | **50-59 years** | **60 – 69 years** | **70-79 years** | **80+** |
| **PSA referral range** | **Use clinical judgement as per NICE guidelines** | **>2.5** | **>3.5** | **>4.5**  |  **>6.5** | **Patients with a healthy life expectancy of less than 10 years do not require urgent referral for mildly raised PSA (<20)** |

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| **For all patients**\*Creatinine\*EGFRResults(within last 3 months)  |  | **\***RecentnegativeMSU *or* Negative urine dipstick required (within the last 4 weeks) | ***MSU / dipstick result:***  |

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| **Accessibility Needs:**☐ Wheelchair access ☐ Deaf☐ Registered blind☐ Learning Disability☐ Other disability needing consideration ☐ Accompanied by carer | **WHO Performance Status:**☐ 0 Fully active☐ 1 Able to carry out light work☐ 2 Up and about greater than 50% of waking time☐ 3 Confined to bed/chair for greater than 50%☐ 4 Confined to bed/chair 100% |
| **RISKS:**☐ Vulnerable Adult (detail below if any recording within last 3 years)☐ No Capacity to Consent Any other known risk:  |

**Additional history/comments (including medications, allergies, major medical history or any recent investigations)**

**\*Please advise if patient is on anticoagulation**