

## Cancer of Unknown Primary Referral Proforma

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS/Key Worker:
Referrer Email:	Referrer phone number:	
Source Hospital:	Source Consultant:	
Referral to QEHB Consultant:	No    Yes	Name:
CWT TARGET DATE:	2WW	UPGRADE
		SUBSEQUENT

Clinical Details: (Include prior treatment, previous chemotherapy, radiology, histology and PMH):

Performance Status: BMI:

Significant Comorbidities:

Current location of patient: Plan:

Is patient known to Palliative Care team?

Specific Palliative Care needs: (Physical/psychosocial)

Reason for referral to CUP team:

**DIAGNOSIS:** **DATE OF DIAGNOSIS:**

**Confirm what patient has been told about diagnosis:**

**Date Patient agreed to transfer care to UHB:**

	Observations Required prior to referral – if not performed state reason why	Location	Date
Histology			
CT Scan of Chest/Abdo/Pelvis <small style="color: red;">Must include full TNM staging.</small>			
Tumour Markers			
Other			

**Ensure all histology and imaging reports are sent with the referral. Staging imaging must have been performed within 6 weeks of referral**

Signature:

Name of person completing form:

Send completed referral form to [UHB-tr.CancerTertiaries@NHS.net](mailto:UHB-tr.CancerTertiaries@NHS.net)  
Please note cut off time for inclusion in MDT is Tuesday 10:00hrs  
To discuss this referral with a member of the CUP team please call 07718 863 905

**Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.**