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| **All patients will be prioritised to a Community Diagnostic Centre if appropriate, otherwise they will be seen at the first available UHB hospital site.**  |

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| **Patient Details:****Surname**: **Forename:**  **Date of Birth:**  **Gender:** **Ethnicity:** **Address:**  **Hospital Number:**  **NHS number:**  **Landline number:** **Mobile number:** **Patient consents to be contacted by text on the above mobile? Y** **[ ]  N** **[ ]** **Interpreter required? Y [ ]  N [ ]** **Main Language:**  **Patient has capacity to consent [ ]**  | **Registered GP Details** **Practice Name:**   **Practice Code:**  **Practice Telephone:**  **Practice Email:**   |
| **Date of Decision to refer:**  |
| **Date of Referral:**  |
|  **Name of referring General Practice**  **Clinician:**   **Name of Registered GP:**   |

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| **WHO Performance Status Scale** (you **MUST** tick box)**:** |
| **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 housework, 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 | [ ]  |

**GP Declaration (please tick)**

[ ]  That they are being referred for urgent investigations for symptoms that could be caused by cancer

[ ]  I have provided the patient with the Urgent Suspected Cancer information leaflet

[ ]  The patient has confirmed that they are available to attend within 2 weeks

[ ]  I have informed the patient that they will be prioritised to be referred to a Community Diagnostic Centre

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| **1** | **ANY ADULT (16 YEARS OR OVER)** PLEASE REFER FOR FIT TEST THE SAME TIME AS THE REFERRAL – **DO NOT WAIT FOR RESULT** | **Tick if present** |
| **a.** | Abdominal mass | [ ]  |
| **b.** | Unexplained rectal mass | [ ]  |
| **c.** | Anal ulceration/mass | [ ]  |

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| **2** | **For the FIT POSITIVE PATHWAY please tick** **[ ]** **Patients MUST be aged ≥ 40 years with a positive FIT (≥10 µg Hb/g) result within 3 months of referral to be eligible** | **Tick all boxes that apply** |
|  | **FIT RESULT** |   µg Hb/g |
| **a.** | **Rectal bleeding** 2 or more episodes in a ≥ 4 week period  | [ ]  |
| **b.** | **Change in bowel habit** Looser/more frequent stools for ≥ 6 weeks | [ ]  |
| **c.** | **Weight loss**Unexplained/Unintentional weight loss Either documented >5% loss in three months or with strong clinical suspicion  | Amount       kgDuration      ([ ]  weeks [ ] months)O/E Weight  O/E previous weight   | [ ]  |
| **d.** | **Iron Deficiency Anaemia**in men (Hb <130g/L) or non-menstruating women (Hb <115g/L) Unexplained and un-investigated in the last 3 years | **Hb**  **g/L****MCV**  **fL****Ferritin**  **ng/mL**  | [ ]  |

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| **3** | **For FIT NEGATIVE patients with Iron Deficiency Anaemia please tick [ ]** In men or non-menstruating women aged ≥ 40 years with a negative FIT (<10 µg Hb/g)Unexplained and un-investigated in the last 3 years**Must include the FIT value and bloods to be eligible for direct to test**  |
|  | **All criteria must be fulfilled for a referral:****(Tick below)**[ ]  **Aged 40 years** [ ]  **FIT NEGATIVE** [ ]  **Ferritin ≤45µg/L** [ ]  **ANAEMIA**  (**Hb <130g/L in men or Hb <115g/L** in non-menstruating women within 3 months of referral)If meeting criteria, please ensure all the following:[ ]  **Dipstick the urine**. (If positive assess for renal cell cancer)[ ]  **Screen for Coeliac disease**.(If positive refer to gastroenterology)[ ]  **Renal function (urea, creatinine, eGFR)** (within 3 months of referral)[ ]  **You have commenced iron treatment**(Date commenced: \_\_\_\_\_\_\_\_\_) | **FIT result:** **µg Hb/g****Hb**  **gL**  **MCV** **fL****Ferritin**  **ng/mL****TTG** **U/mL****Urea** **mmol/L****Creatinine** **µmol/L****eGFR**   **ml/min/1.73m^2>60****\*ALL RESULTS NEEDED**  |
| **4** | **For all other FIT NEGATIVE patients with ongoing NG12 symptoms/signs** Please refer to the FIT negative flow chart to review your options.  |

ENSURE UP TO DATE (WITHIN 3 MONTHS) BLOOD TESTS ARE AVAILABLE ON REFERRAL

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| **ADDITIONAL HISTORY (or attach GP summary with the following details)** |
| **Latest Weight:**   **kg****Last consultation:**   **Active problems:** **Current medication:**  **Allergies and sensitives:** **Smoking status:****Alcohol status:****Pathology results – within 3 months, including FBC, Ferritin, U&Es (within 3 months), AND Urine dipstick, TTG if FIT negative** |

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