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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       kg  Duration  ( 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 |