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| **UHB URGENT CANCER REFERRAL FORM****FOR SUSPECTED UROLOGICAL CANCERS** |
| **INDICATES MANDATORY FIELDS – For Bladder and Prostate cancer please tick UTI has been excluded or the referral MAY NOT BE ACCEPTED** |
| **PATIENT DETAILS** | **GP DETAILS** |
|  **Name:**   | Title Given Name Middle Name Surname  | **Practice Name:**Organisation Name  |
|  |  | **Usual GP Name:** Usual GP Full Name |
| **Address:** | Home Full Address (stacked)  | **Practice Address:**Organisation Full Address (stacked)  |
|  |  | **Practice Code:**Organisation National Practice Code |
|  |  | **Phone No:**Organisation Telephone Number  |
| **NHS Number:** |  NHS Number  | **Practice Email:** Organisation E-mail Address  |
| **Hospital number:** |  Hospital Number  | **Name of referrer:**      |
| **Date of Birth:** | Date of Birth   | **Date of referral:**Long date letter merged  |
| **Interpreter required** | [ ]  **Yes****Language:** Main Language       | [ ]  **No** | **Referrer contact details (if different from above/GP Practice)**      |
| **Sign Language required:** | [ ]  **Yes****Language:** Main Language       | [ ]  **No** |  |
| **Contact Details** **(next 48 hrs):** | **Mobile:** Patient Mobile Telephone **Home:** Patient Home Telephone |  |
|  | **Work:** Patient Work Telephone **Email:** Patient E-mail Address |  |
| **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. |
|   |
| [ ]  The patient has confirmed they are available to attend within the next 2 weeks and is aware they might go Straight To Test (prior to any other hospital contact).  |
|   |
| [ ]  The 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). |
|   |   |   |   |
| [ ]  The patient is aware that they might be contacted for updates from UHB by any means (telephone call, letter, text). |
|  **REASON FOR REFERRAL**  **(All patients)** |
|  |  |
| **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%** |  |
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| **Accessibility Needs:** | [ ]  Wheelchair access [ ]  Deaf [ ]  Registered blind [ ]  Learning Disability [ ]  Other disability needing consideration [ ]  Accompanied by carer |  |
|  |  |  |
| **RISKS:** | [ ]  Vulnerable Adult (detail if any recording within last 3 years\*)  \*Detail ­­­­­     [ ] No Capacity to Consent  Any other known risk:       |  |
|  |  |  |
| **Results**(**within last 3 months**) | [ ]  **Creatinine** Single Code Entry: Serum creatinine level[ ]  **eGFR** Single Code Entry: GFR (glomerular filtration rate) calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation**OR**[ ]  **Bloods have been requested – Results will be available by the time the patient is seen** |  |
| **Diabetes:** | **YES**[ ]  **NO** [ ]  | **Details :**  |  |
| **Anticoagulation:** | **YES**[ ]  **NO** [ ]  | **Details :** |  |
| **All suspected cancer sites** | **Abnormal radiological findings suggestive of urological malignancy**.Please select the appropriate sub-site and attach the relevant report.Abnormalities in radiological investigations suggestive of malignancy override the typical symptoms in the sections below and qualify for this referral pathway. | Prostate [ ] Bladder [ ] Kidneys [ ] Ureter [ ] Testicles [ ] Penis [ ]  |  |
| **Bladder/Renal****(If the UTI excluded box has not been ticked the form will be returned)** | **UTI has been excluded by Dipstick** [ ]  **OR MSU** [ ]  **Date:** (If MSU abnormal please treat UTI and refer to FAQ document) |  |
|  | 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.)  | [ ]  |  |
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|  |  |  |  |
| **Renal** | Palpable renal mass.  | [ ]  |  |
|  | Solid mass in the kidney on imaging. | [ ]  |  |
| **Testis** | (Swelling in body) Non-painful enlargement or change in shape or texture of the testis.  | [ ]  |  |
| **Penile** | Mass or ulcerated lesion, STI excluded/treated, unexplained or persistent symptoms affecting the foreskin or glans. | [ ]  |  |
| **Prostate**(This form is not for the referral of patients with a known prostate cancer diagnosis – please refer urgently to last known consultant)**Prostate** | **PSA value(s) Result**: Single Code Entry: PSA (prostate-specific antigen) level  |  |
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|  |  |  |
|  | For repeated PSA, previous result:       Date:       |  |
|  | **UTI has been excluded by Dipstick** [ ]  **OR MSU** [ ]  **Date:** (GP acknowledges that PSA levels can remain elevated for approximately 4-6 weeks post UTI and has excluded appropriately. Latest dipstick/ MSU results included here.) |  |
|  | **Age** | **Positive PSA referral range** | **Additional notes** |  |
|  | Below 40 years | Use clinical judgement as per NICE guidelines |        |  |
|  | 40 - 49 years | **>2.5** |        |  |
|  | 50 - 59 years | **>3.5** |         |  |
|  | 60 - 69 years | **>4.5** |         |  |
|  | 70 - 79 years | **>6.5** |        |  |
|  | **80 + years\*** | **>20 & asymptomatic**  OR **>7.5 & symptomatic**(bone pain / weight loss) | \* If PSA is between 7.5 - 20, the guidance is to repeat in 6 months and to refer via 2ww if referral criteria met or if PSA has doubled and the patient has a WHOperformance status of 0 or 1.If patients do not fit the outlined criteria but concerns remain, seek appropriate support via “advice and guidance". |  |
|  |  |  |  |  |
|  | **DRE\*** -(Mandatory only if PSA is normal/borderline) | **Benign** (soft/smooth)[ ]   | **Abnormal** (hard/irregular/nodular/ asymmetric) [ ]   |  |
|  |  |  |  |  |
|  |  **MRI Checklist** |  **Does the patient have:** | **Y N** |  |
|  |  | Pacemaker | YES [ ]  NO [ ]  |  |
|  |  | Cranial aneurysm clip / stent / coil | YES [ ]  NO [ ]  |  |
|  |  | Orbital / facial metallic implants | YES [ ]  NO [ ]  |  |
|  |  | Hip replacement  | YES [ ]  NO [ ]  |  |
|  |  | Implanted device/prostheses | YES [ ]  NO [ ]  |  |
|  |  | Any recent surgery (<3 months) | YES [ ]  NO [ ]  |  |
|  | **Family history of Prostate Cancer** | **YES** [ ]   **NO** [ ]   **UNKNOWN** [ ]  | **If yes, details :**  |  |
|  *In patients compromised by co-morbidities or with a below 10 year life expectancy, a discussion with a urologist may be more appropriate. Please consider whether the patient is fit for radical treatment or whether an urgent referral might be more apt.* **Relevant additional history/comments (including medications, allergies, major medical history)****Problems** **Medication** **Allergies** **Consultations**       |  |
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