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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. | | | |
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| I have provided the patient with an Urgent Referral Patient Information Leaflet. | | | |
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| 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). | | | |
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| 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). | | | |
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| 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)** | | | |
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| **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%** | | |  |
|  |  | | |  |
| **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 WHO performance status of 0 or 1.  If patients do not fit the outlined criteria but concerns remain, seek appropriate support via “advice and guidance". |  |
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|  | **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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