**UHB URGENT SUSPECTED CANCER REFERRAL FORM FOR BREAST CANCER IN ADULTS AGED 16 AND OVER – MALE**

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| **DO NOT use for asymptomatic family history or cosmetic surgery (see accompanying FAQ document \* add hyperlink\*)** |
| **PATIENT DETAILS** | **REFERRING CLINICIAN** |
| **Name** | **Name** |
| **NHS Number**  | **Address** |
| **DOB Age** |  |
| **Gender**  |  |
| **Address** | **Practice Code** |
|  | **Tel No** |
| **Tel No:** |  |
| **Mobile No:** | **Email** |
| **Email** | **Decision to refer Date**  |
| **Do you consent to be contacted by text message?: Y N**[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.][Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.] | **Date of Referral**  |
| **Interpreter required?**(specify language) | **Registered GP :** |

**Please tick all boxes to confirm communication with patient**

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| \*I have informed the patient this is an urgent suspected cancer referral verbally and via text (if the patient has consented to receive messages via mobile) | [ ]  |
| \*I have emphasised to the patient the importance of being available over next 10 days for an urgent appointment  | [ ]  |
| \* I have given or sent the patient a copy of the ‘urgent suspected cancer referral patient Information Leaflet’ | [ ]  |
| \* My patient is aware they will be offered the first available appointment at any of these hospitals: Queen Elizabeth (Clinics based at Birmingham Women’s Hospital), Solihull or Good Hope Hospital | [ ]  |

**Please tick to confirm the referral reason.**

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| **Reason for referral** |  |
| Discrete, hard lump ± fixation, ± skin tethering |  |
| With spontaneous unilateral bloody nipple discharge  |  |
| Nipple retraction or distortion of recent onset (<3 months onset) |  |
| Skin distortion/tethering/ulceration / Peau d’orange |  |
| Unexplained axillary lymphadenopathy |  |

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| **Details: (please include duration and site of symptoms)** |
| **Relevant PMH** |
| **Current Medication** |
| **Anticoagulation** |
| **Allergies** |
| **Family Hx breast, ovarian or testicular cancer Yes No**  |
| **Accessibility/Capacity Issues:**Deaf Blind Wheelchair access Learning Disability Other  |

|  |  |
| --- | --- |
| **Accessibility Needs:**☐ Wheelchair access ☐ Deaf☐ Registered blind☐ Learning Disability☐ Other disability needing consideration ☐ Accompanied by carer | **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% |
| **RISKS:**☐ Adult with care and support needs (detail below if any recording within last 3 years)☐ No Capacity to Consent Any other known risk:  |

**Additional history/comments (such as major medical history or any recent investigations)**

**Any referrals received without a completed form will be returned**