**SUSPECTED LOWER GASTRO-INTESTINAL CANCER REFERRAL FORM**

Referrals to be sent via e-RS or e-mail RUH-TR.CancerReferrals@nhs.net

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| **Referrer Details**  | **Patient Details**  |
| Name:  |  | DoB:  |
| Address:  | Address: | Gender:  |
| Hospital No.:  |
| NHS No:  |
| Tel No: | Home No.: | *Please check tel. nos.* |
| Mobile No.: |
| Email:  | Carer requirements (has dementia or learning difficulties)? | Does the patient have the capacity to consent? Yes [ ]  No [ ]  |
| Decision to Refer Date: | Translator Required: Yes [ ]  No [ ]  Language: Communication needs:  | Transport required: Yes [ ]  No [ ] Mobility:  |

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|  | **YES** | **NO** |
| **The patient has been made aware that this is a Suspected Cancer Referral** |  |  |
| **The patient has received the two week wait leaflet** |  |  |
| **The patient has been informed that they may be contacted by secondary care to undergo further tests directly** |  |  |
| **The patient is available to attend appointments/test in the next 14 days-*****If patient is not available for the next 2 weeks, consider reinforcing potential urgency/safetynetting, and only referring when able and willing to accept an appointment.*** |  |  |
| **If your patient is found to have cancer, are there pre-existing psychological factors to be aware of when discussing diagnosis/ further management?**  |  |  |
| **Please confirm you have completed the frailty scale below (needed to assess appropriate onward management including faster, ‘straight to test’ options).** |  |  |

**PATIENT ENGAGEMENT****Clinical details***Please include symptoms and examination findings or attach referral letter.* |

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| **SYMPTOMS & CLINICAL EXAMINATIONS** |
| ***As per cancer alliance and ICB endorsement, and in line with new national guidance to GPs, all patients should have FBC/ferritin and undertake a FIT test with results available prior to referral on this pathway, unless presenting with anal mass/ulceration or abdominal/rectal mass; (or with high risk iron deficiency anaemia)***[ ]  ***qFIT positive >10 Result: \_\_\_\_\_\_\_\_\_\_ µgHb/g Date:*** [ ]  ***Patient unable to undertake qFIT (pls complete Frailty below and outline reason in Clinical Details section)*****Please only access this 2ww pathway for patients who also fulfil one/ more of the following referral criteria:** |
|[ ]  Anal Mass OR ulceration (no qFIT requirement) |
|[ ]  Rectal OR abdominal mass (no qFIT requirement) |
|[ ]  Unexplained rectal bleeding (with qFIT result) |
|[ ]  Unexplained Abdominal pain, weight loss, change in bowel habit or non-iron deficient anaemia WITH documented qFIT +ve result  |
|[ ]  Unexplained iron deficiency anaemia (please consider performing qFIT for pre-menopausal women)  |
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| **Pathway for Colorectal 2ww referral** |

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| **\*GP to consider further investigations as colorectal cancer is unlikely to be the cause of symptoms.****If patients remain symptomatic secondary care referral options include urgent gastroenterology or routine colorectal pathways or consultant discussion via Cinapsis.****If the patient does not fulfil referral criteria OR is qFIT -ve, but a high clinical suspicion of colorectal cancer remains, please consider repeating qFIT at 4-6 week (patients with two negative FIT test results have a colorectal cancer risk of <0.04%) OR seek advice of a consultant colorectal surgeon via Cinapsis.** |

**Blood Results: (Within last 6 weeks)**

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| **FBC** |  |  |
| **UE** |  |  |
| **LFT** |  |  |
| **CRP** |  |  | **ESR** |  |
| **TFTs** |  |  | **INR** |  |
| **Bone** |  |  |
| **Iron** |  |  |
| **Vitamins** |  |  |
| **Lipids** |  |  |
| **Random Glucose** |  | **Fasting Chol.** |  |
| **Fasting Glucose** |  | **HbA1c** |  |

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| **PLEASE TICK AS APPROPRIATE- THIS MUST BE COMPLETED** |
|  **[ ]** **[ ]** **[ ]  [ ]** **[ ]  [ ]** **[ ]** **[ ]** **[ ]**  |
| **Medication:** |
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| **Allergies:****Additional Clinic Information**

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| **Has a Rectal Examination been completed?** |  |
| **Past History of Cancer** |  |
| **Family History** |  |
| **Smoking Status** |  |
| **Alcohol Intake** |  |
| **Is the patient on any Anti-coagulants?** |  |
| **Is the patient on any Anti-platelet therapy?** |  |
| **Is the patient diabetic?** |  |
| **Weight** |  |
| **BMI** |  |

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