# This form should be submitted via the Referral Support Service

# Reference/Priority

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referral Date:   |  | | --- | | Referral Date | | Priority:   |  | | --- | | 2WW | | NHS Number:   |  | | --- | | NHS Number | |

# Patient Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title:   |  | | --- | | Title | | Forename(s):   |  | | --- | | Given Name | | Surname:   |  | | --- | | Surname | |
| Date of Birth:   |  | | --- | | Date of Birth | | Gender:   |  | | --- | | Gender | | Ethnicity:   |  | | --- | | Ethnic Origin | |

# Contact Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address Line 1:   |  | | --- | | Home Address House Name/Flat Number | | Address Line 2   |  | | --- | | Home Address Number and Street | | Address Line 3:   |  | | --- | | Home Address Village | |
| Town:   |  | | --- | | Home Address Town | | County:   |  | | --- | | Home Address County | | Postcode:   |  | | --- | | Home Address Postcode | |
| Phone:   |  | | --- | | Patient Home Telephone | | Mobile:   |  | | --- | | Patient Mobile Telephone | | Text Message Consent:   |  | | --- | |  | |
| Email:   |  | | --- | | Patient E-mail Address | |  |  |

# Referrer/Practice Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referring Name:   |  | | --- | | Referring User | | Referrer Code:   |  | | --- | | Free Text Prompt | | Practice Code:   |  | | --- | | Organisation National Practice Code | |

# Clinic Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Specialty:   |  | | --- | | 2WW | | Clinic Type:   |  | | --- | | 2WW Cancer of Unknown Primary | | Named Clinician:   |  | | --- | |  | |

# Patient Choice Preferences

|  |  |  |  |
| --- | --- | --- | --- |
| Provider 1:   |  | | --- | | Referral Target Service Name | | Provider 2:   |  | | --- | |  | |

# Preferences

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vulnerable Patient:   |  | | --- | |  | | Vulnerable Reason:   |  | | --- | |  | | Confidential/Silent Referral:   |  | | --- | |  | |
| Preferred Contact Time:   |  | | --- | |  | | Interpreter Required:   |  | | --- | |  | | Preferred Language:   |  | | --- | | Main Language | |

# Referral Details

|  |  |
| --- | --- |
| Non-clinical information for the booking team:   |  | | --- | |  | |
| Provisional Diagnosis:   |  | | --- | |  | |
| Smoking Status:   |  | | --- | | Single Code Entry: Smoking Status | |

## Referral Reason/Letter Text

# If your patient does not meet any of the NICE defined 2WW criteria please liaise (by phone or Advice and Guidance) with a specialist or send them in as an urgent referral. Please do not annotate 2WW forms with your own criteria.

# Patient Awareness

|  |  |  |
| --- | --- | --- |
| Confirm that your patient understands that they have been referred onto a “suspected cancer pathway”: | |  | | --- | |  | |
| Confirm that your patient has received the [information leaflet](http://www.valeofyorkccg.nhs.uk/rss/data/uploads/2ww-forms/patient-leaflet-muo-final.pdf): | |  | | --- | |  | |
| Confirm that your patient is available to attend an appointment within 2 weeks of this referral\*\*: | |  | | --- | |  | |
| Confirm that the patient’s renal function (Urea and electrolytes) has been requested and the patient is aware to have the sample taken urgently, to expedite the request for CT Thorax, abdomen and pelvis with contrast: | |  | | --- | |  | |
| \*\*If, after discussion, your patient chooses to notattend within 2 weeks, when will they be available:   |  | | --- | |  | | |

**Please attach all imaging reports**

**Use this form for:** (tick appropriate boxes)

|  |  |  |
| --- | --- | --- |
| Multiple lung metastases on CXR/CT (unless Radiology indicates lung primary) | |  | | --- | |  | |
| Multiple brain metastases on CT/MRI | |  | | --- | |  | |
| Multiple liver metastases on USS/CT/MRI | |  | | --- | |  | |
| Multiple bone metastases on XR/CT/MRI/bone scan (**PSA not raised**) | |  | | --- | |  | |
| Widespread peritoneal infiltration +/-ascites on USS/CT (**CA125 not raised**) | |  | | --- | |  | |
| Other disseminated disease on scan and no site of primary identified (discuss with oncology) | |  | | --- | |  | |

# For advice please contact Oncology on-call at Castle Hill on 01482 875875 and ask for bleep 732.

# Alternatively, you can contact Scarborough (01723) 236236 and ask for the acute oncology nurse.

|  |
| --- |
| * Radiology indicates lung primary - use **Suspected Lung Cancer** form * Multiple bone metastases on XR/CT/MRI/bone scan (**PSA raised**) - use **Suspected Urological Cancer** form * Widespread peritoneal infiltration +/-ascites on USS CT (**CA125 raised**) - use **Suspected Gynaecological** **Cancer** form |

# Patient’s Performance Status (tick one of the following)

|  |  |  |
| --- | --- | --- |
| 0 - Normal activity/well | |  | | --- | |  | |
| 1 - Normal activity but symptomatic | |  | | --- | |  | |
| 2 - Resting but <50% of the day | |  | | --- | |  | |
| 3 - Resting >50% of the day | |  | | --- | |  | |
| 4 - Bed bound/limited mobility for ADL | |  | | --- | |  | |

## Patient Readcoded Values

EHIC: Single Code Entry: European health insurance card (EHIC) held   
Smoking Status: Single Code Entry: Smoking Status   
Religion: Single Code Entry: Religion

## Active Problems

Family History

Problems

Values and Investigations

Allergies

Alcohol Consumption

Smoking

Weight

Height

Blood Pressure

BMI

## Medication

Medication

## Lab Results

Radiology

HbA1c

Urinalysis

Haematology

Lipids

## Diagnostics

ECG

Peak Flow

Cervical Smear