

**Suspected Cancer Unknown Primary (CUP) Referral Form**

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| **Hospital Reference Code: XXOXX** | |
| This referral proforma is intended for the referral of patients who have had imaging suggestive of possible metastatic cancer, without clinical or radiological evidence to indicate a likely primary tumour. If your patient doesn’t meet these criteria but there is clinical concern regarding the possibility of metastatic cancer, please contact the Acute Oncology/CUP team to discuss prior to referral via:  **Macmillian Cancer Navigators: 0300 613 3535** | |
| All GP referrals to the Suspected Cancer Unknown Primary must be submitted using the online NHS e-Referral Service (e-RS) | Speciality **2WW Clinic** Type **– 2WW Cancer of Unknown Primary** |
| Heatherwood and Wexham Park Yes |
| Frimley Park Hospital Yes |
| * Patients who have not already had a CT scan will be booked a CT scan of the chest abdomen and pelvis within 2 weeks of referral, if appropriate. * Your patient will be seen by the CUP team under the urgent suspected cancer pathway if a CT CAP scan shows metastatic disease with no primary tumour. * Prior to referral please arrange a FBC, U&Es, LFTs, Ca, ESR and, in the presence of suspicious bone lesions, additionally a myeloma screen and PSA (in men).   **Please refer to the Frimley Health Suspected Cancer Guidelines before completing this form** | |

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| **Patient Details** | | |
| Surname: |  | Date of Birth: |
| Forename: |  | Sex: |
| Address: |  | Ethnicity: |
| NHS Number: |
| Hospital Number: |
| Interpreter Required? Yes  No |
| First Language: |

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| Please state number(s) for use in the next 24 hours: | Patient agrees to telephone message being left? | Yes  No | |
| Daytime Telephone:  Work Telephone:  Mobile Telephone: | Is the patient aware this is a suspected cancer referral? | Yes |  |
| Is the patient available for 62 days from date of Yes  referral? | Is the patient available for an appointment within the next 14 days? **(if not, please consider deferring this referral until patient becomes**  **available)** | Yes  No |
| Has the patient been given a C ancer Fast track Yes  l eaflet? |

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| **GP Details** | | | |
| GP Name: |  | Telephone Number:  **Direct number if appropriate** |  |
| **Address:** |  | Date of Referral: |  |
| Date Referral Received: |  |

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| **Clinical Information** | | | |
| **Diagnostic imaging suggestive of metastatic disease (and N O primary organ specific symptoms)\*** | | | |
| **USS:** Specify site |  | Date |  |
| **CT scan:** Specify site |  | | |
| **MRI:** Specify site |  | | |
| **Other:** Specify |  | Date |  |

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| **Additional mandatory clinical information required** | | |
| **P lease ensure that relevant U&E’s have been performed and are attached.** | | |
| Please attach summary of past medical history, medication and allergies: | | |
| Referral letter attached? | Yes | No |
| Is the patient on anticoagulant or antiplatelet medication? | Yes | No |

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| **Accessible Information Standards (AIS)** | | |
| Does this patient or their carer have any information/ communication support needs? | Yes | No |
| If yes, please select from below: |  |  |
| Blind | Yes | No |
| Deaf | Yes | No |
| Deaf and blind | Yes | No |
| Low literacy/learning difficulty | Yes | No |
| Mental capacity assessment required? | Yes | No |
| Known safeguarding concerns? | Yes | No |
| Mobility requirements (unable climb on/off bed)? | Yes | No |
| Transport required? | Yes | No |
| Other (please specify): | Yes | No |

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| **Performance Status Key** | | |
| **0** | Fully active, able to carry on all pre-disease performance without restriction |  |
| **1** | Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house or office work. |  |
| **2** | Ambulatory and capable of self care, but unable to carry out work activities. Up and active >50% of waking hours. |  |
| **3** | Capable of only limited self care. Confined to bed or chair >50% of waking hours. |  |
| **4** | Completely disabled. Cannot care out any self care. Totally confined to bed or chair. |  |

\*If patient has a history of cancer please consider whether this is more likely to be a recurrence than a true unknown primary cancer. Patients with suspected recurrence should be referred back to the site specific team.

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| **Free text box for additional clinical information/Referral letter** |
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| **Past Medical History**  **Please use this area to autopopulate a patient summary:** to include recent consultations, current diagnoses; past medical history; recent investigations; recent blood test results; medication; any other fields which might be helpful to secondary care. |
| **Recent Consultations** |
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| **Current Diagnosis (Current Problems)** |
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| **Past Medical History** |
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| **Recent Investigations (free text)** |
|  |
| **Recent Blood Test Results (free text)** |
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| **Medication** |
|  |
| **Allergies** |
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| **FBC**  U&Es LFTs  Ca  ESR PSA |



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| Contact: |  |
| Contact Title: |  |
| Contact Email: |  |
| Date First Uploaded: | January 2021 |

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| Review Date: | November 2025 |
| Date Updated: | November 2023 |
| New Review Date: |  |

Feedback Contact: D [XSfrimleyICS@nhs.net](mailto:XSfrimleyICS@nhs.net)

*(Note, patient information is not to be sent to this address)* FHC1679