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| Please refer to the Frimley Health Suspected Cancer Guidelines before completing this form. | |
| **Hospital Reference Code: XSSSX** |
| **Suspected Lower GI Cancer Referral Form** |
| **Please refer to the Frimley Health Suspected Cancer Guidelines before completing this form.** |
| **All GP referrals to the Suspected Lower GI Cancer Pathway must be submitted using the online NHS e-Referral Service (e-RS).**  **Fax is no longer supported due to patient safety and confidentiality risks**  **All referrals should be made within 24 hours.** |
| **Speciality:** 2ww **Clinic Type:** 2ww Lower GI |

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| **Tick the Hospital Site you wish to refer** | | | | | | | | | |
| Heatherwood and Wexham Park Yes | |  |  | | | | | | |
| Frimley Park Hospital Yes | |  |  | | | | | | |
| **Patient Details** | | | | | | | | | |
| Surname: |  | | | Date of Birth: |  | | | | |
| Forename: |  | | | Sex: |  | | | | |
| Address: |  | | | Ethnicity: |  | | | | |
|  | NHS Number: |  | | | | |
|  |  | | | Hospital Number: |  | | | | |
|  |  | | | Interpreter Required? | | Yes |  | No |  |

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| Please state number(s) for use in the next 24 hours: | | | Patient agrees to telephone message being left? | | | | |
| Telephone Number(s): | | | Yes |  | No |  |  |
|  | | | Is the patient aware this is a suspected cancer referral? | | | | |
|  | | | Yes |  |  |  |  |
|  | | | Is the patient available for an appointment within the next 14 days? **(if not, please consider deferring this referral until patient becomes available)** | | | | |
| Is the patient available for 62 days from date of referral? | Yes |  |
| Has the patient been given a [Suspected Cancer Fast track leaflet](dxs://SECTION=CPD,ITEMLEVEL=ARTICLE,ITEMCODE=FHC1048)? | Yes |  | Yes |  | No |  |  |
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| **GP Details** | | | |
| GP Name: |  | Telephone Number:  **Direct number if appropriate:** |  |
|  |  | Practice Email: |  |
| Address: |  | Date of Referral: |  |
|  |  | Date Referral Received: |  |

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| ***Age Threshold*** | **Symptom description** | **X** | | |
| All Ages  **U&E, FBC and Ferritin required** | **Rectal mass** - A definite palpable rectal (not pelvic) mass |  |  |  |
| **Abdominal mass** - A definite palpable abdominal mass |  |  |  |
| **Unexplained anal mass / ulceration** |  |  |  |
| **Endoscopy results suggestive of cancer** |  |  |  |
| Aged 50 and over  **U&E, FBC and Ferritin required** | **Unexplained rectal bleeding for 4 weeks** |  |  |  |
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| All the below patients must have a **Faecal Immunochemical Test (FIT)** completed with result >10 in addition to below symptoms:  **U&E, FBC, Ferritin and coeliac antibody** | | | | |
| Aged 40 and over | **Unexplained weight loss AND abdominal pain + FIT>10** |  |  |  |
| Aged under 50 | **Unexplained rectal bleeding, + FIT>10 AND any of the following:** |  |  |  |
| **Abdominal pain** |  |  |  |
| **Change in bowel habit** |  |  |  |
| **Unexplained weight loss** |  |  |  |
| **Iron deficiency anaemia** |  |  |  |
| Aged 60 and over | **Changes in their bowel habit** |  |  |  |
|  | **Iron deficiency anaemia +FIT>10** |  |  |  |
| Any age | Referral due to ongoing **clinical concern, progressive or alarm symptoms** despite FIT <10 (see additional guidance and FAQs for further information) – please provide detail in free text box below – **FBC, U&E, Ferritin and coeliac antibody** |  |  |  |
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| Free text box: (FIT<10) |  |  |  |  |

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| **Additional MANDATORY clinical information required** | | | | | | | | | | | | |
| Please ensure the following recent results are available: | | | | | | | | | | | | |
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| Blood test (less than 8 weeks old): | | | | | | | | | | | | |
| eGFR | | | | or date of test | | |  | | | | | |
|  | | | | | | | | | | | | |
| Hb | | | | or date of test | | |  | | | | | |
|  | | | | | | | | | | | | |
| MCV | | | | | or date of test |  | | | | | | |
|  | | | | | | | | | | | | |
| **Ferritin** | | | | | or date of test |  | | | | | | |
|  | | | | | | | | | | | | |
| **Coeliac antibody** | | | | | or date of test |  | | | | | | |
|  | | | | | | | | | | | | |
| **Faecal Immunochemical Test** | | | | | | | | | | | | |
| FIT | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
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| **If Applicable:** | | |  | | | | | | | | | |
| Date of last colonoscopy: | | |  | | | | | | | | | |
| Date of last OGD: | | |  | | | | | | | | | |
| **Frailty Assessment Score:** | | | | | | | | | | | | |
| 1 |  | **Very Fit** – robust, fully active, energetic and motivated and exercise regularly. | | | | | | | | | | |
| 2 |  | **Well** – no active disease symptoms but are less fit than category 0. occasionally exercise (Able to carryout light work) | | | | | | | | | | |
| 3 |  | **Managing Well** – medical problems are well controlled, but are not regularly active beyond routine walking. (Up and about 80% of waking time) | | | | | | | | | | |
| 4 |  | **Vulnerable** – While not dependent on others for daily help, symptoms limit activities (tired during the day). | | | | | | | | | | |
| 5 |  | **Mildly Frail** – often have more evident slowing, and need help in high order IADLs (progressively impairs light work). | | | | | | | | | | |
| 6 |  | **Moderately Frail** – need help with all outside and household activities including self-care. | | | | | | | | | | |
| 7 |  | **Severely Frail** – Completely dependent for personal care, (physical or cognitive), but stable and not at high risk of dying within 6 months. (Confined to bed/chair 50%) | | | | | | | | | | |
| 8 |  | **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness. (No self-care, confined to bed/chair 100%) | | | | | | | | | | |
| 9 |  | **Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail. | | | | | | | | | | |
| **Information required to assess fitness for further investigations** | | | | | | | | | | | | |
| Is that patient fit for bowel prep at home? | | | | | | | | Yes |  | No |  |  |
| Is the patient fit for day case sigmoidoscopy? | | | | | | | | Yes |  | No |  |  |
| Is the patient taking iron? | | | | | | | | Yes |  | No |  |  |
| Is the patient anticoagulated? *(please ensure this is specified in the medication list)* | | | | | | | | Yes |  | No |  |  |
| Is the patient diabetic? | | | | | | | | Yes |  | No |  |  |
| Is the patient on hypertensive medication? | | | | | | | | Yes |  | No |  |  |

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| **Free text box for additional clinical information / Referral letter / COVID RISK STATUS / ISOLATION STATUS** |
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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** |
|  |
| **Current Diagnosis** |
|  |
| **Past Medical History** |
|  |
| **Recent Investigations (free text)** |
|  |
| **Recent Blood Test Results (free text)** |
|  |
| **Medication** |
|  |
| **Other Information** |
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| **Accessible Information Needs (AIS):** |  |