 

 **Suspected Cancer Non-Specific (Vague) Symptoms (NSS) Referral Form**

*Delivery of safety netting for patients on urgent referral pathway for suspected cancer 🞏*

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| **Please view the Suspected Cancer Non-Specific Symptoms (Suspected Cancer Non-Specific Service) Referral Guide at hhttps://**[**www.fhft.nhs.uk/gps/gp-centre/referrals-key-contacts/**](http://www.fhft.nhs.uk/gps/gp-centre/referrals-key-contacts/) **before completing this form.** |
| This referral proforma is intended for patients with “Non Specific but Concerning Symptoms” and clinical signs that could present cancer or serious disease, but that do not already have a designated pathway for urgent investigation or referral.Please note that all patients will go straight to have a CT Chest Abdomen Pelvis scan. If no cancer or other new pathology is diagnosed the patient will be discharged to you with a summary of the test results and clinical f iindings**.**If . If patient has a history of cancer within the last 5 years, please consider if this may be recurrence rather than a true unknown primary cancer.  Patients with suspected recurrence or under active surveillance should be referred back to the site specific team.**If the patient has had a CT Chest Abdomen Pelvis in the last 12 months patient will not be accepted.**  |
| A[ll GP referrals to the NSS Pathway must be submitted using the NHS](https://www.fhft.nhs.uk/gps/gp-centre/referrals-key-contacts/) e-Referral Service (e-RS). Referrals sent by email or by post from GPs **will not** be processed. **Please ensure you select the correct clinic / hospital / service according to patient location as shown to the right.** | [**Frimley Park Hospital**](https://www.fhft.nhs.uk/gps/gp-centre/referrals-key-contacts/)**Specialty:** 2WW**Clinic Type:** Non-Specific Symptoms |
| **Wexham Park Hospital****Specialty:** 2WW**Clinic Type:** Non-Specific Symptoms |
| **FAILURE TO FILL IN EACH SECTION OF THIS FORM MAY LEAD TO DELAYS IN THE REFERRAL PROCESS** |

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| **Patient Details Patient’s background and culture** |
| Surname: |  | Ethnicity: |  |
| Forename: |  | 1st Language: |  |
| Title: |  | NHS Number: |  |
| DOB: |  | Hospital Number: |  |
| Sex: |  | Age: |  | Interpreter required? Yes No |
| Address: |  | **GP Details** |
| Referring GP: |  |
| GP address: |  |
| Please state number(s) for use in the next 24 hours: |
| Telephone DaytimeNumber(s): WorkMobile |
| Patient agrees to telephone call/text message being sent?Yes No | Practice email: |  |
| If no, please state other preferred alternative i.e. email address | GP Tel No: |  |

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| **Suspected Cancer Non-Specific Symptoms NSS Referral Communication Checklist - p lease select** |
| **NOTE: It is essential that you answer all questions in this section** |
| The patient has been advised that the diagnosis could possibly be cancer and they understand they may need a CT Chest Abdomen Pelvis and further investigations if indicated. | Yes |  |  |  |
| No |  | * why not?
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| The patient has been advised and confirmed they will be available for an appointment within the next 7 days and can be contacted by phone. |  |  |  |  |
| Yes |  |  | *NB. Please only submit this referral when**the answer is Yeeeessss* |
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| The patient has been counselled regarding the referral process and offered a copy of the **F ast Track Suspected Cancer Patient****I nformation Leaflet**? Offering written patient information increases patient experience and reduces non-attendance. | YesNo |  | * why not?
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| **REFERRAL CRITERIA** |
| **Please briefly outline the main reason for referral / current health issue of concern and select relevant symptoms below:***(to reduce delays please give as much information as possible)* |
| **Checklist** | **PLEASE SELECT TO CONFIRM ALL PREREQUISITE TESTS HAVE BEEN COMPLETED PRIOR TO REFERRAL****– referrals sent without required test results will be redirected back to GP** |
| 18 years of age |
| Patient is fit and suitable for a CT Chest Abdomen Pelvis investigation |
| **Referral Criteria**Select all that apply | New unexplained and unintentional weight loss (5% in the last 3 months) | Amount: | Duration: | Current weight: |
| New unexplained constitutional symptoms (4 weeks or more)Persistent nausea Loss of appetite Fatigue Malaise Bloating |
| New unexplained, unexpected or progressive pain including bone pain (4 weeks or more) | **Duration weeks** |
| New unexplained vague abdominal pain – **please attach the most recent ultrasound scan report** |
| GP Clinical Suspicion of cancer or serious disease/GP “gut feeling” – reasons to be described clearly: |
| Duration of symptoms:Number of A&E Visits / GP / Out of Hours / 111 consultations with these symptoms: Past / Family history of cancer including date of diagnosis: |
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| **Investigations required to support referral**Please note that all patients will go straight to have a CT Chest Abdomen Pelvis scan. Please ensure the following recent blood results are available **(within four weeks).****I**  |
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| **Chest X-Ray** | Date of Chest X-Ray: | Where Performed: |  |
| **Symptomatic FIT Test**If **positive**, please refer urgently to the specific cancer pathway | Date and Result of Test: | If **positive**, please refer urgently to the Lower GI cancer pathway | Yes No |
| **Urine dipstick**If **positive**, please refer urgently to Urology cancer pathway | Date and Result of Test: | If **positive**, please refer urgently to Urology cancer pathway | Yes No |

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| FBC Or date of test |
| U&Es with eGFR Or date of testU&E (urea and electrolytes)eGFR |
| ESR and/or CRP Or date of testESR-Erythrocyte Sedimentation RateCRP (C-Reactive Protein) |
| Protein electrophoresis Or date of test |
| LFTs Or date of test |
| HbA1c Or date of test |
| INR Or date of test(if on warfarin)or Full coagulation screen(if otherwise clinically indicated) |

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| B12/Ferritin/Folate (if anaemic) B12FerritinFolate |  | Or date of test |
| Bone Profile |  | Or date of test |
| TSH |  | Or date of test |
| CA125 (women)/PSA (men) CA125PSA |  | Or date of test |
| Coeliac screen/TTG (optional if clinically appropriate)Coeliac ScreenTTG (tissue transglutaminase) |  | Or date of test |
| HIV (optional if clinically appropriate) |  | Or date of test |
| Is the patient on anticoagulant or antiplatelet medication? YesIf yes, please state the reason why the patient is taking medication and the medication AnticoagulantAntiplatelet | No |  |
| **Relevant past clinical history** *(please provide as much detail as possible)* |
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| Current medication and allergies: (Attach printout) MedicationAllergies |
| Past Medical History (including psychological or mental health if any of note): |
| Attachments: Letter: | Medication List: | Other: |
| **MANDATORY BOX FOR ALL PATIENTS – WHO PERFORMANCE SCORE**Enter score to establish if patient is suitable for straight to CT scan |
| **0** | **Fully active**, able to carry out 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 carry out any self-care. Totally confined to bed or chair. |

# R ockwood Clinical Frailty Score (please select)

1. **Very Fit** – robust, fully active, energetic and motivated and exercise regularly
2. **Well** – no active disease symptoms but are less fit than category 1. Occasionally exercise (able to carry out 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 instrumental activities of daily living (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.

**WEXHAM PARK OR FRIMLEY PARK HOSPITAL:** For questions about the NSS process or patient eligibility, please contact the NSS Patient Navigator at fhft.nss@nhs.net or by calling0300 613 3535.

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| **FOR OFFICIAL USE ONLY***((( (* ***(This section to be completed by the Navigator upon receipt of the referral)*****DATE REFERRAL RECEIVED: REFERRAL ACCEPTED BY: REDIRECTED****Reason(s):** Incomplete NSS criteria not metOther Briefly state the reason for redirection:If redirected but triaged to appropriate or specific suspected cancer pathway, please state the site: |  | Alternative pathway available |
| I have notified the referring GP Practice: | Yes | **DATE:** |

# Accessible Information Needs (AIS):



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

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| Review Date: | February 2026 |
| Date Updated: | February 2024 |
| New Review Date: |  |

Feedback Contact: D XSfrimleyICS@nhs.net

*(Note, patient information is not to be sent to this address)* FHC3003