NHS Birmingham and Solihull Integrated Care Board

NHS University Hospitals Birmingham NHS Foundation Trust

CT TAP WEIGHT LOSS IMAGING REFERRAL FORM

PATIENT DETAILS		REFERRER DETAILS	
Name:		**Usual GP:**	
Address: **Postcode:**		**Practice Address:**	
		Practice Code:	
NHS Number:		**Practice Phone No:**	
Hospital number:		**Practice Email:**	
Date of Birth:		**Name of Referrer:**	
Referral date:		**Referrer Mobile No:**	
		Referrer Role:	
Special Needs:	☐ Capacity to consent ☐ Sight ☐ Hearing ☐ Oxygen ☐ Barrier ☐ Interpreter Language:	**Mobility :**	☐ Walk ☐ Chair ☐ Bed ☐ Mobile imaging req. ☐ Escorted
Preferred Contact No:	**Home:**	**Work:**	**Mobile:**
Patient consents to be contacted by text message?:	☐ Yes ☐ No		
Preferred Hospital:	QEHB ☐ Heartlands ☐ Solihull ☐ Good Hope ☐		

Procedure or Examination requested:	**Patient Medical Status**	
	Allergies:	
	Pregnancy:	☐ Yes ☐ No
Clinical Question and Relevant Information:	**Breast Feeding:**	☐ Yes ☐ No
	Asthmatic:	☐ Yes ☐ No
	Diabetic:	☐ Insulin ☐ Metformin
	Exams requiring contrast:	☐ U&E Test Underway eGFR:
	MRI use only (Please tick if the patient has the following)	
	☐ Pacemaker ☐ Aneurysm clip ☐ Metal foreign Body ☐ Operation within 3/12	

Click here for current imaging referral guidelines: **https://www.uhb.nhs.uk/gps/referrals/imaging/**

OFFICE USE ONLY

Imaging Notes	***Imaging Audit Data***	
	Received Date:	
	Operator:	
	Signature:	

REQUEST FOR CT TAP: (All of the following criteria must be fulfilled for the referral to proceed)

PATHWAY CHECK LIST: (Please tick to confirm that all criteria have been met)

- ☐ **Aged ≥40 years**
- ☐ **Strong Suspicion of malignancy after face to face consultation**
- ☐ **Have significant, unexplained and persistent weight loss over 4-6 weeks (time frame and kg,)**

  _____ (at least 5-10% OF BODY WEIGHT)
- ☐ **Routine bloods have been performed and are within normal range**
- ☐ **FIT NEGATIVE** ☐ ug HB/g
- ☐ **Have an Additional Symptom and/or Sign (Please type):**

  _____
- ☐ **Patient not pregnant*** **LMP Date _____**

*If LMP is greater than 7 days, please provide a pregnancy test result along with the request and ask patient to abstain from sex / protected sex.
*Pregnancy Disclaimer form to be signed by patient on arrival.

If your patient does not fulfil the above criteria (e.g. has isolated weight loss only without an additional symptom), and you have a strong suspicion of malignancy please use the 2WW NSS (Non-specific symptom) referral form.

Referrer Declaration – Please confirm and tick

- ☐ GP Direct Access Pathway referral criteria completed above
- ☐ Email header states the request is Urgent
- ☐ The patient is aware that they may be offered the first available appointment at any of the UHB sites
- ☐ I understand that failure to complete the form correctly will result in rejection and the form being returned

Referrer name and signature: **Date:**
(If form manually completed)

Please submit your completed referral form to the following email inbox based on your patient's preferred hospital **stating in the email header** that the request is **Urgent**

Queen Elizabeth Hospital	**CT-Bookings@uhb.nhs.uk**
Heartlands Hospital	**BHHImagingreferrals@uhb.nhs.uk**
Solihull Hospital	**SOLImagingreferrals@uhb.nhs.uk**
Good Hope Hospital	**GHHImagingreferrals@uhb.nhs.uk**

IT IS VITAL AN NHS DOMAIN EMAIL IS INCLUDED IN THE REFERRER DETAILS. This will allow us to send urgent but non critical findings (i.e. suspected cancer) for your attention. Failure to include an appropriate email will result in the form being returned.