

**URGENT CHEST X-RAY REFERRAL FORM**

Please only use this form for **SUSPECTED INTRATHORACIC MALIGNANCY**  
or as a prerequisite for a **NON-SPECIFIC SYMPTOMS** pathway referral

PATIENT DETAILS		REFERRER DETAILS	
<b>Name:</b>		<b>Referring GP name:</b>	
<b>Date of birth:</b>		<b>GMC no:</b>	
<b>Address and postcode:</b>		<b>GP Practice code:</b>	
		<b>GP Practice Tel no:</b>	
<b>Hospital number:</b>		<b>GP Practice address and postcode:</b>	
<b>NHS number:</b>			
<b>Special needs:</b>	<input type="checkbox"/> Capacity to consent <input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Oxygen <input type="checkbox"/> Barrier <input type="checkbox"/> Interpreter Language:	<b>GP Practice email:</b>	
		<b>Date of referral:</b>	
<b>Mobility:</b>	<input type="checkbox"/> Walk <input type="checkbox"/> Chair <input type="checkbox"/> Bed <input type="checkbox"/> Escorted <input type="checkbox"/> Hospital Transport* Comments: <i>(free text here)</i>	<b>Patient preferred location:</b>	
		QEHB <input type="checkbox"/> Solihull <input type="checkbox"/> Good Hope <input type="checkbox"/> Heartlands <input type="checkbox"/> Washwood Heath CDC* <input type="checkbox"/>	
<b>Contact no:</b>	<b>Home:</b>	<b>*Please note that Washwood Heath offer a walk in service but cannot accept patients who require hospital transport.</b>  <b>Examination requested:</b> Urgent Chest X-ray (with/without CT as required)  <b>Clinical question and relevant information:</b>	
	<b>Work:</b>		
	<b>Mobile:</b>		
<b>Patient consents to be contacted by text message?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Patient medical status:</b>	<b>Allergies:</b>		
	<b>Pregnancy:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Breast Feeding:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Asthmatic:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Diabetic</b>	<input type="checkbox"/> Insulin <input type="checkbox"/> Metformin	
<b>eGFR (&lt;6mths)</b>	Value:		

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

**OFFICE USE ONLY**

<b>Imaging Notes</b>	<b>Imaging Audit Data</b>	
	<b>Received Date:</b>	
	<b>Operator:</b>	
	<b>Signature:</b>	

## INDICATION FOR URGENT CHEST X-RAY REQUEST:

Please select **one** of the following options below:

- Urgent CXR required as a prerequisite for referral onto the NSS pathway
  - Proceed to **Referrer declaration** section
  - Please note that this referral form is for **urgent CXR only**.
- Urgent CXR required for investigation of possible intrathoracic malignancy
  - Please complete the **Referral criteria for suspected intrathoracic malignancy** and **Referrer declaration** sections

## REFERRAL CRITERIA FOR SUSPECTED INTRATHORACIC MALIGNANCY:

Please select smoking/asbestos exposure history:

- History of active/previous/passive smoking or prior asbestos exposure
- No history of smoking or asbestos exposure

If there is a history of active/previous/passive smoking or prior asbestos exposure, **one** of the below is required (please tick):  
If there is no history of smoking or asbestos exposure, **two** of the below are required (please tick):

- Cough (unexplained) > 4-6 weeks
- Chest pain (unexplained) > 4-6 weeks
- Shortness of breath (unexplained) > 4-6 weeks
- Weight loss, > 4-6 weeks - 5-10% of body weight
- Appetite loss > 4-6 weeks
- Fatigue > 4-6 weeks
- Unexplained hemoptysis

If the above referral criteria for suspected intrathoracic malignancy are not met, please use a standard CXR referral form.

## REFERRER DECLARATION:

Please **confirm** and tick **all** of the below:

- The patient has been provided with the *Important information regarding CXR referrals from your GP* information leaflet.  
<https://www.uhb.nhs.uk/services/imaging/chest-x-ray-referral-gp.htm>
- You have discussed with the patient that if clinically indicated from the CXR result, the hospital will automatically arrange for a CT chest (+/- abdomen) scan for the patient – as per UHB DXCT pathway
- The GP will act as the named referrer for both the CXR and any resulting CT request, and is also responsible for acting on non-lung cancer CT scan findings – as per DXCT pathway
- An eGFR result within 6 months is available for the patient/underway
- Once completed, I have printed signed and also emailed to the relevant site below.  
For Washwood Heath CDC, I have printed and signed and handed to the patient to attend the walk in service (08:00–20:00). Please note that Washwood Heath is unable to accept transport patients. If your patient requires hospital transport or is unable to travel to this site please indicate in the Mobility section on page 1\*
- I understand that failure to complete the form fully and correctly will result in rejection and the form being returned

**GP Referrer name and signature:**

**Date:**

Please submit your completed referral form to one of the following email inboxes based on your patient's preferred hospital. Please state in the email subject that this request is '**Urgent**'. If the referral is to the Washwood Heath walk in service, please also give a paper copy of the request form to the patient to bring with them.

Queen Elizabeth	<a href="mailto:PlainFilm-Bookings@uhb.nhs.uk">PlainFilm-Bookings@uhb.nhs.uk</a>	Heartlands	<a href="mailto:BHHImagingreferrals@uhb.nhs.uk">BHHImagingreferrals@uhb.nhs.uk</a>
Solihull	<a href="mailto:SOLImagingreferrals@uhb.nhs.uk">SOLImagingreferrals@uhb.nhs.uk</a>	Good Hope	<a href="mailto:GHHImagingreferrals@uhb.nhs.uk">GHHImagingreferrals@uhb.nhs.uk</a>
Washwood Heath CDC	<a href="mailto:WWHCXdirect@uhb.nhs.uk">WWHCXdirect@uhb.nhs.uk</a>		

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