Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

Cancer of Unknown Primary Referral Proforma

Patient Name: QEHB/NHS Number: D.O.B:

Patient Address: Patient Tel No: GP:

Referring Hospital: Referring Consultant: CNS/Key Worker:

Referrer Email: Referrer phone number:

Source Hospital: Source Consultant:

Referral to QEHB Consultant: No Yes Name:

CWT TARGET DATE: 2WW UPGRADE SUBSEQUENT

Clinical Details: (Include prior treatment, previous chemotherapy, radiology, histology and PMH):

Performance Status: BMI:

Significant Comorbidities:

Current location of patient: Plan:

Is patient known to Palliative Care team?

Specific Palliative Care needs: (Physical/psychosocial)

Reason for referral to CUP team:

DIAGNOSIS: **DATE OF DIAGNOSIS:**

Confirm what patient has been told about diagnosis:

Date Patient agreed to transfer care to UHB:

	Observations Required prior to referral – if not performed state reason why	Location	Date
Histology			
CT Scan of Chest/Abdo/Pelvis Must include full TNM staging.			
Tumour Markers			
Other			

Ensure all histology and imaging reports are sent with the referral. Staging imaging must have been performed within 6 weeks of referral

Signature:

Name of person completing form:

Send completed referral form to SarcomaMDT@uhb.nhs.uk

Please note cut off time for inclusion in MDT is Tuesday 10:00hrs

To discuss this referral with a member of the CUP team please call 07718 863 905

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.