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| **Patient Details:**  **Surname: Forename:**  **DoB: Gender:**  **Ethnicity:**  **Address:**  **Hospital Number:**  **NHS number:**  **Landline number:**  **Mobile number:**  **Patient consents to be contacted by text on the above mobile? Y**  **N**  **Interpreter required? Y  N**  **First Language:**  **Patient has capacity to consent? Y  N** | **Registered GP Details:**  **Practice code:**  **Fax no:**  **Telephone:**  **Email:** |
| **Date of Decision to refer:** |
| **Date of Referral:** |
| **Name of referring General Practice**  **Clinician:**  **Name of Registered GP:**  **Clinician Signature:** |

**GP Declaration**

* They have symptoms which may be caused by cancer
* I have informed the patient:
* That they are being referred to the rapid access suspected cancer clinic
* The nature of the tests likely to take place
* I have provided the patient with a 2 week wait information leaflet



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| FIT RESULT: |

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| **1** | ANY ADULT (16 YEARS OR OVER) PLEASE REFER FOR FIT TEST THE SAME TIME AS THE REFERRAL  DO NOT WAIT FOR FIT RESULT | **Tick if present** |
| **a.** | Abdominal mass |  |
| **b.** | Unexplained rectal mass |  |
| **c.** | Anal ulceration/mass |  |

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| **2** | **FIT POSITIVE PATHWAY**  **Patients MUST be aged ≥ 40 years with a positive FIT (≥10 µg Hb/g) result and have one or more of the following:** | | **Tick if present**  **Must include the FIT value** |
| **a.** | **Rectal bleeding**  2 or more episodes in a ≥ 4 week period | | FIT result:        µg Hb/g |
| **b.** | **Change in bowel habit**  Looser/more frequent stools for ≥ 6 weeks | | FIT result:        µg Hb/g |
| **c.** | **Weight loss**  Unexplained/Unintentional weight loss  Either documented >5% loss in three months or with strong clinical suspicion | Amount      kg  Duration  ( weeks months)  O/E Weight      kg  O/E previous weight      kg | FIT result:        µg Hb/g |
| **d.** | **Iron Deficiency Anaemia** in men (Hb <130g/L) or non-menstruating women (Hb <115g/L)  Unexplained and un-investigated in the last 3 years | Hb     g/L MCV     fL  **Ferritin**      ng/mL | FIT result:        µg Hb/g |



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| **3** | **FIT NEGATIVE patients with Iron Deficiency Anaemia**  In men or non-menstruating women aged ≥ 40 years with a negative FIT (<10 µg Hb/g)  Unexplained and un-investigated in the last 3 years  **Tick if present - Must include the FIT value and bloods below** | |
|  | **All criteria must be fulfilled for a referral:**  **(Tick below)**  **Aged 40 years or over AND**  **FIT NEGATIVE AND**  **Ferritin ≤45µg/L AND**  **ANAEMIA**  (Hb <130g/L in men or  Hb <115g/L in non-menstruating women)  If meeting criteria, please ensure all the following:  **Dipstick the urine**.  (If positive assess for renal cell cancer)  **Screen for Coeliac disease**.  (If positive refer to gastroenterology)  **Renal function (urea, creatinine, eGFR)**  (MUST be within 3 months)  **You have commenced iron treatment**  (Date commenced      ) | **FIT result:**      µg Hb/g  **Hb**        g/l  **MCV**       fL  **Ferritin**       ng/mL  **TTG**       U/mL  **Urea**       mmol/L  **Creatinine**       µmol/L  **eGFR** ml/min/1.73m^2>60 |
| **4** | **For FIT NEGATIVE patients with ongoing NG12 symptoms/signs**  Please refer to the FIT negative flow chart to review your options. | |

ENSURE UP TO DATE (WITHIN 3 MONTHS) BLOOD TESTS ARE AVAILABLE ON REFERRAL

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| **ADDITIONAL HISTORY (or attach GP summary with the following details)** | |
| **Last consultation:**    **Active problems:**  **Current medication:**  **Allergies and sensitives:**  **Smoking status:**  **Alcohol status:**  **Pathology results – last 6 months:**  TTG (If FIT Negative)  Urine Dipstick (If FIT Negative):  Including FBC, Ferritin, U&Es (within 3 months), AND Urine dipstick, TTG if FIT negative | |
| **\* PLEASE COMPLETE FOR ALL REFERRALS:** | |
| \*WHO Performance status (see scale below, please tick one) 0  1  2  3  4 | |
| **WHO Performance Status Scale:** | |
| **WHO Grade** | **Explanation of activity** |
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours |
| 3 | Capable of only limited self-care, confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair |

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| **For 2ww office use only**  Page 1of **2** | | |
| Date referral received | Triage date | Consultant |