# URGENT REFERRAL FOR SUSPECTED GYNAECOLOGICAL CANCER IN ADULTS

# (AGED 16 AND OVER)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | **GP Details** | | | | | |
| **Name:** |  | | | **Name:** | | |  | | |
| **Address:** |  | | | **Address:** | | |  | | |
|  |  | | |  | | |  | | |
|  |  | | | **Phone No:** | | |  | | |
| **NHS Number:** |  | | | **Fax No:** | | |  | | |
| **Hospital number:** |  | | | **Name of referrer:** | | |  | | |
| **Date of Birth:** |  | | | **Decision to refer date:** | | |  | | |
| **Interpreter/Sign Language required:** | ☐ Yes ☐ No | | | **Language:** | | |  | | |
| **Contact No (next 48 hrs):** | **Home:** |  | **Work:** | | |  | | **Mobile:** |  |
| **Patient consents to be contacted by text message?:** | | | | | | | | Yes  No | |
| **GP Declaration – Please confirm and tick**  I have informed the patient they have symptoms which may be caused by gynaecological cancer, that they are being referred urgently, and the nature of the tests likely to take place.  I have provided the patient with an Urgent Referral Patient Information Leaflet.  My patient has confirmed they are available to attend within 2 weeks.  My patient is aware that they will be offered the first available appointment at any one Birmingham Women’s Hospital, Solihull Hospital, Good Hope Hospital or Birmingham Heartlands Hospital. | | | | | | | | | |
| |  |  | | --- | --- | | **Reason for Referral** | **TICK** | | **Ovarian** | | | 1. Refer the woman urgently if physical examination identifies ascites and/or a pelvic or abdominal mass (**which is not obviously uterine fibroids**)      1. Pelvic Ultrasound or CT/MRI imaging suggestive of Ovarian Cancer     (Elevated CA125 **35-69 in pre menopausal women with** the below symptoms**, do not** **use this form**, refer via the Ovarian cancer pathway on the 2WW Urgent Pelvic scan premenopausal referral form). |  | | 1. Elevated CA125 **≥35 in post menopausal women with** the below symptoms.      1. Elevated CA125 **≥ 70 in pre menopausal women with** the below symptoms.     As Per NICE, the following symptoms should be referred as associated with elevated CA125.  Persistent abdominal distention/bloating Feeling full (early satiety) and/or loss of appetite, pelvic or abdominal pain, increased urinary urgency and/or frequency, unexplained weight loss, fatigue, or changes in bowel habit. |  | | CA125 Result within 3 months. |  | | **Endometrial/Uterine**  \*Please refer to the British Menopause Society guidance on **PMB** and \***HRT Guidance** [04-BMS-TfC-HRT-Guide-NOV2022-A.pdf (thebms.org.uk)](https://thebms.org.uk/wp-content/uploads/2022/12/04-BMS-TfC-HRT-Guide-NOV2022-A.pdf) | | | Post-menopausal bleeding **not on HRT** (Post-menopausal in absence of periods for 12 months; please DO NOT refer peri-menopausal bleeding under this criterion).  Of note: peri-menopausal bleeding in high risk women such as PCOS, BMI over 40 should be referred urgently for a pelvic scan. |  | | Post-menopausal bleeding persistent/unexplained **after cessation of HRT for 6 weeks** \* |  | | Women **on HRT** with persistent abnormal bleeding after 6 months of starting HRT\* |  | | Dysfunctional bleeding **on Tamoxifen** |  | | Women diagnosed with **Lynch Syndrome** with abnormal bleeding |  | | Asymptomatic postmenopausal women with ultrasound scan findings of endometrial thickness **≥** 10mm.  For heavy perimenopausal bleeding over 45 yrs despite medical treatment consider urgent gynaecology referral.  For the post-menopausal bleeding criteria - I confirm the vulva, vagina and cervix are normal.  (This is minimum set criteria ) |  | | | | | | | | | | |
| |  |  | | --- | --- | | If referral for PMB, has patient been previously investigated for this within the last 12 months | Yes  No | | **Cervical**  (\*Post-coital bleeding and intermenstrual bleeding with a normal cervix is not an indication for 2WW \*see **PCB** guidance.  For persistence unexplained PCB age less than 25 years consider urgent referral to Gynaecology). | | | Appearance of the cervix on the speculum examination is consistent with cervical cancer: Suspicious lesion on cervix.   |  |  | | --- | --- | | **SMEAR** |  | | **TRIPLE RESULTS** |  | |  | | **Vulval/Vaginal** | | | Unexplained lump or suspicious lesion |  | | Bleeding due to ulceration |  | | **Recurrence of Cancer** | | | Suspicion of recurrence of known gynaecological cancer  Date and type of previous Gynaecological cancer |  | | |  |  | | --- | --- | | \*To aid clinical triage please arrange prior to referral or import from EMIS: U&E’s required to facilitate CT scan with contrast if necessary:  **If you have a scan report, please attach it to this referral. It will stop patient from having another scan appointment.** | | | U&Es and eGFR Result (within last 3 months)  Pelvic Ultrasound Scan report result if available | Results       Date:  Requested | | | | **Please detail any clinical findings and relevant clinical information in this section (including any recent investigations).** | | | |  | | --- | | **Please attach the practice print out for medication, past medical history, repeat medications, allergies, recent investigations.** | | **Last Consultation** | | | | Please indicate whether the patient has had a hysterectomy | Yes  No | | Body Mass Index – within the last year |  | | I confirm I have performed a gynaecological examination covering the vulva, vagina and cervix. |  | | | | | | | | | | |
| **PATIENT MEDICAL DATA:**  **Comorbidities:** Click here to enter text.  **Any allergies/anticoagulation’s:** Click here to enter text.  **BMI:** Click here to enter text. | | | | | | | | | |
| **Accessibility Needs:**  ☐ Wheelchair access  ☐ Deaf  ☐ Registered blind  ☐ Learning Disability  ☐ Other disability needing consideration  ☐ Accompanied by carer | | | | | **WHO Performance Status:**  ☐ 0 Fully active  ☐ 1 Able to carry out light work  ☐ 2 Up and about greater than 50% of waking time  ☐ 3 Confined to bed/chair for greater than 50%  ☐ 4 Confined to bed/chair 100% | | | | |
| **RISKS:**  ☐ Vulnerable Adult (detail below if any recording within last 3 years)  ☐ No Capacity to Consent  ☐ If no capacity to Consent please confirm that a “best interest” meeting has been held and evidence of outcome is attached below.  Any other known risk: | | | | | | | | | |

**Please be aware that forms that contain missing data or are incorrectly completed will be returned to the Practice for correction and resubmission.**