Rapid assessment of patients with non-specific symptoms and clinical signs that could represent cancer or serious disease, but do not already have a designated pathway for urgent investigations or referral. Use Cancer Maps to support decision making if unsure.

|  |  |
| --- | --- |
| Patient | Referrer |
| Title | <Patient Name> | Surname | <Patient Name> | GP Name (registered GP) | <Sender Name> |
| First Name | <Patient Name> | GP Name (referring GP) | <Sender Name> |
| Address | <Patient Address> | GP Telephone Number | <Sender Details> |
| Postcode | <Patient Address> | Date of Birth | <Date of birth> | GP Address | <Sender Address> |
| Gender | <Gender> | Age | <Patient Age> | GP fax number | <Sender Details> |
| Telephone (Home) | <Patient Contact Details> | Is an interpreter required? |  Yes [ ]  No [ ]  |
| Telephone (Mobile) Patient consents to receive communication by mobile | <Patient Contact Details> Yes [ ]  No [ ]  | If so, which language? | <Main spoken language> |
| Telephone (Work) | <Patient Contact Details> |  |
| NoK name / contact number | <NoK Contact Details> | If transport is required, GP must arrange transport for first visit. |
| NHS Number | <NHS number> | Date of decision to Refer |       |
| E-mail address | <Patient Contact Details> | Date of Referral | <Today's date> |
| **Patient Access Information Requirements**: *<relating to physical ability, mental capacity or communication considerations>*

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| --- | --- | --- |
| Able to carry out all normal activity (0) [ ]   | Restricted in physically strenuous activity, but able to walk and do light work (1) [ ]  | Able to walk and capable of all self care, but unable to carry out any work. Up and about more than 50% of waking hours (2) [ ]  |
| Capable of only limited self care, confined to bed or chare more than 50% of waking hours (3) [ ]  | **Mental capacity *(Narrative if needed)*** |
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| **Does the patient have any medical devices or implants?** Yes [ ]  No [ ] If yes, please state what device <Device Details> |
| ***Smoking Status***

|  |  |  |
| --- | --- | --- |
| Current smoker (1) [ ]  | Ex-smoker (2) [ ]   | Non-smoker - history unknown (3) [ ]  |
| Never smoked (4) [ ]  | Not stated (PERSON asked but declined to provide response) (Z) [ ]  |  |

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| **Alcohol consumption**

|  |  |  |
| --- | --- | --- |
| Heavy (>14 units per week) (1) [ ]  | Light (≤ 14 units per week) (2) [ ]  | None ever (3) [ ]  |
| Not stated (PERSON asked but declined to provide response) (z) [ ]  |  |
|  |  |

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| **Presenting Symptoms**

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| --- | --- | --- |
| **Age 40+ AND****unexplained weight loss***(either documented >5% in three months or with strong clinical suspicion)* | Unexplained weight loss Amount (kgs) {free text} Duration (weeks/months) {free text} [o/e weight] - most recent reading[o/e weight] - previous reading x 1 | [ ]  |
| **Age 40+ AND****constitutional symptoms***(+4 weeks)* | Persistent and unexplained constitutional symptoms such as loss of appetite, fatigue, nausea and / or vomiting, malaise, bloating.(Document in free text below) | [ ]  |
| **Age 40+ AND****persistent pain***(+4 weeks)* | Persistent and unexplained pain such as vague abdominal pain, bone pain or progressive pain. (Document in free text below) | [ ]  |
| **Any age** | GP ‘gut feeling’An intuitive opinion that there is something seriously wrong with your patient which might have cancer as a possible cause(Document in free text below) | Duration (weeks/months)       /       |

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| **Symptoms on presentation *and reason for referral (Narrative)***For ‘GP Gut instinct’ this field must be completed before form can be sent**Date of first primary care presentation with non-specific symptoms**      **Number of primary care presentations relating to non-specific symptoms**       |
| **Primary Care pre-referral actions**1. Please confirm the patient is aware of the possible diagnosis of cancer. Explain the urgency and importance of attendance to appointment due to the suspicion of cancer. [ ]
2. Please confirm the patient information leaflet has been given. [ ]
3. Please confirm the patient is available & willing to attend an appointment within the next 7 calendar days if required. [ ]
4. Please confirm that you have completed ALL the following filter function tests, which can be found on Order Comms/ICE by clicking on the ‘Clinical Page’ tab. Failure to do so may result in your referral being rejected and/or delay in your patient’s investigations

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| --- | --- | --- | --- | --- | --- |
| CXR [ ]  | LFTS [ ]  | Urine dipstick [ ]  | FIT [ ]  | FBC [ ]  | ESR and/or CRP [ ]  |
| Location CXR done: | U&E with eGFR [ ]  | Bone [ ]  | LDH [ ]  | Immunoglobulins [ ]  | TSH [ ]  |
| HBA1c [ ]  | PSA (Men) [ ]  | CA-125 (Women) [ ]  |  |  |

1. Please confirm that you have attached to this referral form a summary of past medical history and medications [ ]
2. Patients who receive a significant disease diagnosis including non-cancer will be internally referred within secondary care to the most appropriate service. All other patients will be referred / discharged back to primary care.
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**PLEASE NOTE: IF YOUR PATIENT IS ELDERLY AND HAS MULTI-MORBIDITIES REQUIRING HOLISTIC REVIEW OR COMPREHENSIVE GERIATRIC ASSESSMENT PLEASE REFER TO ELDERLY MEDICINE OUTPATIENTS.**