**SUSPECTED LOWER GASTRO-INTESTINAL CANCER REFERRAL FORM**

**Use the ICE system first for Straight To Test where appropriate.**

**Only use this form when indicated by the ICE system colorectal two week wait referral process.**

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| **Referrer Details**  | **Patient Details**  |
| Name: **Free Text Prompt**        | **Forename:****Given Name**  | **Surname:****Surname**  | **DOB:** **Date of Birth**  |
| Address:**Organisation Full Address (stacked)**  | **Address:****Home Full Address (stacked)**  | **Gender:** **Gender(full)** |
| **Hospital No:** **Hospital Number**  |
| **NHS No:** **NHS Number**  |
| Tel No:**Organisation Telephone Number**  | **Tel No. (1):** **Patient Home Telephone**  | ***Please check telephone numbers*** |
| **Tel No. (2):** **Patient Mobile Telephone**  |
| Email:**Organisation E-mail Address**  | **Carer requirements (has dementia or learning disabilities)?** | **Does the patient have the capacity to consent?****Yes [ ]  No [ ]**  |
| Decision to Refer Date:**Short date letter merged**  | **Translator Required: Yes** **[ ]  No [ ]** **Language:** | **Mobility:** |

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| **Level of concern**[ ]  *I think it is likely that this patient has cancer, and I would like the patient to be investigated further even if the first test proves negative, including a Consultant to Consultant referral if deemed appropriate. All non-site specific symptoms (e.g. iron deficiency anaemia, unexplained weight loss) are listed in the clinical details section below.***Clinical details***Please detail your conclusions and what needs to be excluded or attach a referral letter.*Consultations  |

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| **This group of patients should have a FIT test over ≥10ug/g (FIT positive) for a 2WW referral.**Referrals received without a qFIT result (when this is indicated and the patient is capable of taking the test) will be returned to the referring clinician for the qFIT to be completed to guide the most appropriate pathway for the patient as per national and local guidance.FIT Value       µg/g**FIT≥10ug/g AND** [ ]  ***Aged 40 and over*** with unexplained weight loss and abdominal pain ***or***[ ]  ***Aged 60 and over*** with changes in their bowel habit[ ]  ***Aged 50 and over*** with unexplained rectal bleeding[ ]  ***Aged*** **under** ***50*** with rectal bleeding ***and*** any of the following unexplained symptoms or findings: [ ]  Abdominal pain [ ]  Change in bowel habit [ ]  Weight loss [ ]  Iron-deficiency anaemia**FIT≥10ug/g** with **unexplained symptoms** that could be attributable to colorectal cancer[ ]  **Aged 18 or over** with symptoms that could be attributable to colorectal cancer, please detail symptoms below |
| **This group of patients do not require a FIT test prior to referral****Colorectal cancer** [ ]  Rectal mass[ ]  ***Aged 60 and over*** with Iron-deficiency anaemia[ ]  Abdominal mass **Anal cancer**[ ]  unexplained anal mass or unexplained anal ulceration  |
| [ ]  Patient unable to perform FIT test and still requires referralPlease give details  |
| [ ]  FIT negative (<10ug/g) but clinically concerned, with progressive or alarm symptomPlease consider alternative diagnoses including whether patient meets the criteria for an alternative 2ww pathway or whether a routine referral or advice and guidance may be appropriate. Please give detailsPlease note that in referring a patient under this criterion I agree that if clinical triage in secondary care determines the patient does not require a fast track pathway, I will consent to my fast track referral being downgraded to a non-cancer pathway and the patient continuing on an urgent or routine pathway or being returned to primary care with advice and guidance.  |
| **Information required to book patient into the right type of appointment*** Is the patient **fit** for oral bowel preparation/colonoscopy and **willing** to undergo this type of procedure[ ]  Yes [ ]  No

(See Remedy for exclusion criteria and when referring please print out the information leaflet for colorectal cancer from Remedy to give to the patient.)* Please can you make sure that the patient has a recent eGFR (i.e. 3 - 6m depending on co-morbidities) at the point of referral to enable them to proceed to endoscopy if appropriate. For patients referred to Weston please ensure results within the last 3 months

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| eGFR |  | Date  |

* ***If referring for iron-deficiency, these results are essential***

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| Ferritin |       | Date |
| Hb |       | Date |

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| **Smoking status****Smoking**  | **Rockford Clinical frailty Scale:** [ ]  **1** Very Fit[ ]  **2** Well, no active disease symptoms, active occasionally[ ]  **3** Managing well**,** medical problems are well controlled not regularly active [ ]  **4** Vulnerable, not dependent, symptoms limit activity[ ]  **5** Mild frail, more evident showing, high order IADLs[ ]  **6**  Moderately frail, needs help with all outside activities, help with bathing[ ]  **7** Severely frail, completely dependent for personal care[ ]  **8** Very Severely Frail, completely dependent, approaching end of life[ ]  **9** Terminally Ill  |
| **BMI if available****BMI**  |

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| Please confirm that the patient has been made aware that this is a suspected cancer referral: [ ] Yes [ ] NoPlease confirm that the patient has received the urgent fast track referral leaflet: [ ] Yes [ ] NoPlease provide an explanation if the above information has not been given:     If your patient is found to have cancer, do you have any information which might be useful for secondary care regarding their likely reaction to the diagnosis (e.g. a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological or emotional readiness for further investigation and treatment?      |
| Date(s) that patient is unable to attend within the next two weeks:      ***If the patient is not available for the next 2 weeks, and is aware of the nature of the referral, consider seeing again to reassess symptoms and refer when able and willing to accept an appointment.*** |

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| **Please attach the additional clinical issues list from your practice system****Details to include:**Medication Problems Allergies Family History Alcohol Consumption Current medication, significant issues, allergies, relevant family history, alcohol status and morbidities |

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| **Trust Specific Details:** |

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| ***For hospital to complete*** UBRN: Received date: |

**Refer to:**

UHB [ ]  NBT [ ]  Weston [ ]