**BNSSG Suspected Gynaecology Cancer Referral Form**

**Referral should be sent via e-RS with this form attached within 24 hours**

Please ensure all fields are completed, this will help ensure the patient is seen in the most appropriate clinic and in a timely way. Requesting additional information can delay appointments.

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| Referral date: **Short date letter merged** | Patient’s hospital of choice: [     ] |
| 1. **REFERRER DETAILS – ESSENTIAL**
 |
| Usual GP name: **Free Text Prompt** | Referring clinician: **Free Text Prompt** |
| Practice code:       | Practice address: **Organisation Full Address (stacked)**  |
| Practice name:       | Email: **Organisation E-mail Address** |
| Main Tel: **Organisation Telephone Number** | Practice bypass number       ***(manual entry)*** |

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| 1. **PATIENT DETAILS - ESSENTIAL**
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| Surname: **Surname** | First name: **Given Name** |
| NHS number: **NHS Number** | Title: **Title** |
| Gender on NHS record: **Gender(full)**  | Gender Identity: **Free Text Prompt** ***(manual entry)*** |
| Ethnicity:       | Hospital No.: **Hospital Number** |
| DOB: **Date of Birth**  | Age:       |
| Patient address: **Home Full Address (stacked)** |
| Daytime contact Tel:       **Home:** **Patient Home Telephone** **Mobile:** **Patient Mobile Telephone** *Please check telephone numbers* |
| Email:       |
| Does the patient have the capacity to consent? Yes [ ]  No [ ]   |
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| **Carer/ key worker details:** |
| Name:         | Contact Tel:        |
| Relationship to patient:       |  |

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| 1. **REASON FOR REFERRAL– ESSENTIAL**

[See Remedy Gynaecology Cancer Referral information](https://remedy.bnssg.icb.nhs.uk/urgent-suspected-cancer-usc/gynaecology-usc-2ww/) |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:***       |
| 1. **SPECIFIC CRITERIA FOR URGENT REFERRAL – ESSENTIAL**
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| [ ]  **Criteria for urgent referral suspected ENDOMETRIAL CANCER:** |
| Before referral please confirm the patient has a uterus and examine the patient to assess for alternative causes eg cervical cancer Please tick one of the following:[ ]  Post menopausal bleeding NOT ON HRT. Any unexplained vaginal bleeding >12 months after menstruation has stopped due to the menopause[ ]  Unscheduled bleeding ON HRT with 1 major risk factor or 3 minor risk factors as per BMS ‘Management of Unscheduled Bleeding on HRT’ guideline (see table below)[ ]  Unscheduled bleeding ON HRT with an ultrasound demonstrating one of the following:* Endometrial thickness of greater than or equal to 4mm on continuous combined (bleed-free) HRT.
* Endometrial thickness of greater than 7mm on sequential HRT
* Endometrium incompletely visualised or suspicion of a polyp

[ ]  Incidental finding of Endometrial thickness greater than or equal to 10mm in women who are asymptomaticUnscheduled Bleeding on HRT Risk Factors

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| Major Risk Factors | * BMI >40
* Genetic Predisposition (Lynch or Cowdens Syndrome)
* Oestrogen only HRT for >6months in women with a uterus
* Tricycling HRT (quarterly progesterone) for >12 months
* Prolonged sHRT regimen: >5yrs when started in women aged >= to 45
* 12 months or more of using NET or MPA for <10 days/month or micronised progesterone <12days/month as part of sHRT regimen.
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| Minor Risk Factors | * BMI 30-39
* Oestrogen Only HRT for >3 months but <6months in women with a uterus
* Tricycling HRT (quarterly progesterone) for >6 months but <12months
* Insufficient progesterone to oestrogen dosing (inc expired 52mg LNG- IUS) for >12months
* Anovulatory cycles such as PCOS
* >6months but <12months using NET or MPA <10dyas/month or micronised progesterone <12days/a month as part of sHRT
* Diabetes
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Please provide information on the IUS at the point of referral as this may be offered at their OPA*For heavy peri-menopausal bleeding over 45 / irregular bleeding / heavy menstrual bleeding despite medical treatment, consider an urgent referral to General Gynaecology as per NICE guidelines.* |

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| [ ]  **Criteria for urgent referral suspected OVARIAN CANCER:** |
| [ ]  Physical examination identifies ascites (without known cardiac/liver cause) and/or a pelvic or abdominal mass (which is not obviously uterine fibroids)[ ]  Ultrasound suggests ovarian cancer *Please attach report**Please perform CA125 test FBC and U&E* ***in parallel*** *with referral (plus LDH, BHCG, AFP if the patient is under 40 years of age)* |
| [ ]  **Criteria for urgent referral suspected CERVICAL CANCER:** |
| [ ] Appearance of cervix consistent with cervical cancer. ***One of the following should also usually be present:****• Post-coital, intermenstrual or post-menopausal bleeding • Abnormal, persistent vaginal discharge (infection excluded)****For persistent unexplained post-coital bleeding please send swabs to exclude infection, request pelvic USS and consider a referral to Gynaecology/colposcopy*** |
| [ ]  **Criteria for urgent referral suspected VULVAL CANCER:** |
| [ ] Unexplained vulval lump, ulceration, bleeding or concern about vulval intraepithelial neoplasia (VIN) Consider referring to GUM clinic in pre-menopausal patients |
| [ ]  **Criteria for urgent referral suspected VAGINAL CANCER:** |
| [ ] Unexplained palpable mass in or at entrance to vagina For suspected bartholins abscess please refer via gynae emergency clinic |
| [ ]  **Criteria for urgent referral OTHER:** |
| **[ ]** Referral is due to clinical concerns that do not meet above criteria – **please provide full details in Section 1.*****If the patient does not meet any specific criteria above, please consider the following alternatives:*** *• Obtain Advice & Guidance from a specialist • Routine referral**to a**gynaecology service* |
| **Menopausal status:**[ ]  Pre-Menopausal [ ]  Post-Menopausal [ ]  Hysterectomy [ ]  Patient on HRT |

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| 1. **INVESTIGATIONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL**
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| **Please confirm which (if any) investigations have been completed:**[ ]  Pelvic Ultrasound / [ ]  Abdominal Ultrasound/ [ ]  Transvaginal Ultrasound (suspected ovarian / endometrial cancer)[ ]  CA 125 (suspected ovarian cancer) [ ]  UE (suspected ovarian cancer – to guide use of contrast in imaging)[ ]  FBC (heavy vaginal bleeding)[ ]  Results of latest smear[ ]  Chlamydia test in primary care in cases of post coital bleeding |

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| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL**
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| **WHO Performance status**  |
| [ ]  **0** Fully active[ ]  **1** Restricted physically but ambulatory and able to carry out light work[ ]  **2** Ambulatory more than 50% of waking hours; able to carry out self-care**[ ]  3** Limited self-care; confined to bed or chair more than 50% of waking hours**[ ]  4** Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair |
| **Other access needs -** *please detail per the selected options in the field below* |
| [ ]  Interpreter required - If Yes, Language:      [ ]  Transport required[ ]  Mobility needs[ ]  Wheelchair access required | [ ]  Cognitive impairment including dementia[ ]  Learning disability [ ]  Autism[ ]  Mental health issues that may impact on engagement[ ]  Severe mental illness |
| Details of access needs:       |

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| 1. **ADDITIONAL IMPORTANT CLINICAL INFORMATION**
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| Past history of cancer:       |
| Relevant family history of cancer:       |
| Safeguarding concerns:       |
| Other relevant information about patient’s circumstances:       |
| Patient referred/previously investigated for similar symptoms at other hospital/service? [ ]  No [ ]  Yes, please give details:       |

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| [ ]  I have discussed the **possible diagnosis of cancer** with the patient |
| [ ]  I have provided the patient the urgent fast track referral leaflet [(Patient Information & Safety Netting)](https://remedy.bnssg.icb.nhs.uk/urgent-suspected-cancer-usc/patient-information-safety-netting/) |
| [ ]  I have advised the patient to **prioritise this appointment & confirmed they’ll be available within the next 14 days.** |
| [ ]  The patient has been advised that the hospital **may contact them by telephone** |
| [ ]  The patient has been advised that their first appointment may be for an USS/CT/MRI or out-patient hysteroscopy. |
| [ ]  Patient added to the practice **safety-netting system** where available |
| Where required please provide additional information here concerning the above questions eg patient has dates that they are not available       |

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| 1. **CONSULTATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS**
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| ***Please note: You will need to add pending test results, requests and relevant excluded medical history (e.g. trans history, sexual health, private patients) manually in the text boxes below.*** |
| Consultations: **Problems** |
| Medical history:       |
| Medication: **Medication** |
| Allergies: **Allergies** |
| Imaging studies (in the past 12 months): Date:        Location:             |
| Renal function (in the past 6 months):       |
| Full blood count (in the past 6 months):        |
| Test results pending (type of investigation) :       Trust / Organisation:       Date:             |
| All Values and Investigations (in the past 6 months):       |
| BMI (latest): **BMI** |
| Weight (latest):      |
| Blood Pressure (latest):       |
| Safeguarding history:       |
| Smoking status: **Smoking**  |
| Alcohol Consumption: **Alcohol Consumption** |

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| **Trust Specific Details**      |

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

**Refer to:**

UHB [ ]

NBT [ ]

Weston [ ]