**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.

|  |  |  |
| --- | --- | --- |
| 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)*** | |

|  |  |
| --- | --- |
| 1. **PATIENT DETAILS - ESSENTIAL** | |
| 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 | |
|  | |
| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |

|  |  |
| --- | --- |
| 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** | |
| **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 post-menopausal women who are asymptomatic  Unscheduled Bleeding on HRT Risk Factors   |  |  | | --- | --- | | 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. | | 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 |   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.* | |

|  |
| --- |
| **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 arrange blood tests/request imaging in parallel with the referral according to the* [*Primary Care Pathway - Ovarian Cyst/Mass on Transvaginal US*](https://remedy.bnssg.icb.nhs.uk/media/fgvftym1/primary-care-pathway-ovarian-cyst-on-tvuss-updated-08-05-25.docx) |
| **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 |

|  |  |
| --- | --- |
| 1. **INVESTIGATIONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL** | |
| **Please confirm which (if any) investigations have been completed or requested:**  Pelvic Ultrasound /  Abdominal Ultrasound/  Transvaginal Ultrasound /  CT /  MRI  CA 125  AFP/LDH/bHCG (only indicated if suspicious ovarian mass/cyst <40 y/o)  UE (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 |

|  |  |
| --- | --- |
| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL** | |
| **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: | |

|  |
| --- |
| 1. **ADDITIONAL IMPORTANT CLINICAL INFORMATION** |
| 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: |

|  |
| --- |
| 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 |

|  |
| --- |
| 1. **CONSULTATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS** |
| ***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** |

|  |
| --- |
| **Trust Specific Details** |

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

**Refer to:**

UHB

NBT

Weston