**SUSPECTED COLORECTAL CANCER REFERRAL FORM**

THIS FORM IS DESIGNED FOR SUSPECTED CANCER REFERRALS ONLY

Upon receipt of this form, information will be assessed and the patient will be contacted with a clinic appointment or diagnostic test. Please ensure your patient is aware of reason for referral and possible investigations.

***PLEASE USE THE ELECTRONIC E-REFERRAL SYSTEM TO DIRECTLY BOOK APPOINTMENT – THE PROFORMA NEEDS TO BE ATTACHED TO THE UBRN WITHIN 24 HOURS***

Telephone Contact No. for Booking Queries: 0151 604 7720

Prior to referral please address:

|  |  |
| --- | --- |
| Is the patient currently taking iron tablets?If yes, has the patient been informed to stop taking their iron tablets with immediate effect (as per GP referral guidance communication) thus enabling the patients diagnostic pathway to progress? | Yes [ ] No [ ]Yes [ ] No [ ] |
| If the patient is female has ovarian cancer been considered?Please consider urgent USS +/- CA 125 blood test | Yes [ ] No [ ] |
| If the patient is **> 60** and has **weight loss** with any of **abdominal pain/back pain/diarrhoea/constipation/nausea/vomiting/new-onset diabetes** please arrange urgent **CT abdomen/pelvis** (US if CT contraindicated) to exclude **pancreatic cancer** (if no recent CT done within 6 months) | Yes [ ] No [ ] |
| Has an infective cause been excludedHas the patient had any other test prior to this referral? Details: | Yes [ ] No [ ] |

**Patient information and availability**

|  |  |
| --- | --- |
| Has the patient been informed about the 2ww pathway and why they are being referred? | Yes [ ] No [ ] |
| Has the patient been given the 2-week wait information leaflet? | Yes [ ] No [ ] |
| Is the patient available for the next 4 weeks? | Yes [ ] No [ ] |
| Does the patient have capacity to give consent? | Yes [ ] No [ ] |

|  |
| --- |
| **Referring to:** |
| **Date of referral:**  | **Date of Decision to Refer:** |

**Patient Details**

|  |  |
| --- | --- |
| **NHS No.** | **Gender:** |
| **Surname:** | **Forename:** | **Title:** |
| Address: | Home tel. no.Mobile tel no.Preferred contact no.Overseas or temporary Yes [ ] No [ ]visitor |
| **Practice details** Practice address:  | GP CodeReferring GPPractice CodeTel. No.Fax No. |
| **Culture, Mobility, Impairment Issues**  |
| Interpreter required Yes [ ] No [ ] Language?Ethnic GroupReligion | Any disability Yes [ ] No [ ]If yes, please specifyTransport Required Yes [ ] No [ ] |

**REFERRAL INFORMATION**

Does the patient fall into any of the following categories? Please answer YES or NO

|  |  |
| --- | --- |
| Unexplained **abdominal pain** and **weight loss Aged 40+** | Yes [ ] No [ ] |
| Unexplained **rectal bleeding Aged 50+** | Yes [ ] No [ ] |
| Unexplained **change in bowel habit** **Aged 60+** | Yes [ ] No [ ] |
| **Aged 50-** with **rectal bleeding and** any of **abdominal pain/weight loss/change in bowel habit/iron deficiency anaemia** (<12g/dl in men or <11g/dl in women) | Yes [ ] No [ ] |
| **Any age** with right sided lower abdominal mass consistent with involvement of the large bowel | Yes [ ] No [ ] |
| Positive faecal occult blood test (**FOB**) | Yes [ ] No [ ] |
| **Any age** with a rectal mass (intraluminal and not pelvic) | Yes [ ] No [ ] |
| Unexplained **iron deficiency anaemia** (<12g/dl in men or <11g/dl in women) **Age 60+;** please give values below | Yes [ ] No [ ] |
| Haemoglobin |  |
| Ferritin  |  |
| Positive coeliac test  | Yes [ ] No [ ] |
| Microscopic haematuria | Yes [ ] No [ ] |
| Unexplained **anal mass** or **anal ulceration** | Yes [ ] No [ ] |
| **Clinical Details** (Details of history, investigations) |
| **Examination carried out including PR** (please complete to enable triage to most appropriate 1st test):  |

**Fitness for Investigations**

|  |  |
| --- | --- |
| Has the patient had an MI during the last 3 months? | Yes [ ] No [ ] |
| Is the patient fit for bowel prep (Moviprep) at home | Yes [ ] No [ ] |
| Is the patient capable, with help, of climbing onto an examination couch, lying flat and turning onto their side? | Yes [ ] No [ ] |

Please grade the patient using the scale below:

|  |  |
| --- | --- |
| **Grade** | **ECOG** |
| **0** | Fully active, able to carry on all pre-disease performance without restriction |
| **1** | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| **2** | Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours |
| **3** | Capable of only limited self-care, confined to bed or chair more than 50% of waking hours |
| **4** | Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair  |

**Past Medical History**

|  |  |
| --- | --- |
| Diabetes mellitus (please circle) | NoDiet/Tablet/Insulin |
| Cardiac disease |  |
| Respiratory disease |  |
| Implantable cardiac defibrillator | Yes [ ] No [ ] |
| Cardiac pacemaker | Yes [ ] No [ ] |
| eGFR<90 | Yes [ ] No [ ] |

**Medication**

|  |  |
| --- | --- |
| Iron tablets | Yes [ ] No [ ] |
| Anticoagulants | Yes [ ] No [ ] |
| Please specify |  |
| Antiplatelet drugs | Yes [ ] No [ ] |
| Please specify |  |

**Allergies**

|  |  |
| --- | --- |
| Iodine/Radiology contrast | Yes [ ] No [ ] |
| Other (please specify) | Yes [ ] No [ ] |

**Family history**

|  |  |
| --- | --- |
| Colorectal cancer (please specify with age) | Yes [ ] No [ ] |
| Gastric/Liver/Ovarian/Uterine/Urinary tract/Brain/Small bowel (please circle | Yes [ ] No [ ] |
| Inflammatory bowel disease | Yes [ ] No [ ] |

**Additional information**

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