**BREAST REFERRAL FORM**

**(for both suspected and non-suspected cancer referrals)**

**PLEASE INDICATE :Urgent - Suspected Cancer ☐ Symptomatic & Cancer Not Suspected ☐**

***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

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| **PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD** |
| 1. **Has the patient been counselled regarding this referral as per the NICE guidelines i.e. advised why they have been referred to a cancer service and offered appropriate information including where to seek additional support? (this does not include symptomatic patients where cancer is not suspected).**

**If no, please explain why:** | Yes ☐ No ☐ |
| 1. **Has the patient been advised that they need to be available within the next four**

**weeks? – this applies to all breast referrals regardless of indication****If no, please explain the reason why:** | Yes ☐ No ☐ |
| **3.** **Have you ensured that the telephone contact details are correct?** | Yes ☐ No ☐ |
| **REFERRER’S DETAILS** |
| **Referring GP** |  | **GP Code:** |
| **Registered GP** |  |
| **GP Address & postcode** |  |
| **GP Tel. No.** |  |
| **GP Fax. No.** |  |
| **Date seen by GP:** |  | **Decision to refer date:** |
| **PATIENT DETAILS** |
| **Title & Surname** |  | **Forename(s)**  |
| **D.O.B.** |  | **AGE:** | **Gender:** Male**☐** Female**☐** |
| **Address**  |  |
| **Postcode** |  | **\*Tel. No. (day)**  | **Mobile Tel.**  |
| **\*Tel. No. (evening)**  |  | **NHS No.**  |  |
| **CULTURAL, MOBILITY, IMPAIRMENT ISSUES** |
| What is the patient’s preferred first language? ………………………………………………..Does the patient require Translation or Interpretation Services? YES ☐ NO ☐ ………………………………………Please list any hearing or visual impairments requiring specialist help (Sign language, Braille, Loop Induction systems) ………………………………………………………………………………………………………Is Disabled Access Required? YES ☐ NO ☐ Is transport required? YES ☐ NO ☐ ……………………… Ethnic Origin: ……………………………………….. Religion: ………………………………………………………Is the patient from overseas? YES ☐ NO ☐ Is the patient a temporary visitor? YES ☐ NO ☐  |

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| **REFERRAL INFORMATION** |
| For patients **younger than 30** with an unexplained breast lump with or without pain use this form adding any relevant information in the free text box below or attached clinical record. If in doubt refer to the advice below re contacting the local specialist. |
| **30+ and older, with:*** Unexplained breast lump with or without pain
* Unexplained lump in axilla

**50+ and over with:** Unilateral nipple changes including one of the following:o Dischargeo Retractiono Other changes of concern (describe in the free text box below)**Patients of any age, with:**o Skin changes that suggest breast cancer | Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐ |
| **Site**Axillary R ☐ L ☐ Upper Outer Quadrant R ☐ L ☐ Lower Outer QuadrantR ☐ L ☐ Upper Inner Quadrant R ☐ L ☐ Lower Inner Quadrant R ☐ L ☐ |
| Discussion with a specialist (for example, by telephone or email) should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical. **[2015].** |
| **This is a free text box to facilitate any additional information which might not be in the main clinical record particularly with reference to symptomatic patients under 30 where cancer is not suspected.** |
| **Please use this area during formatting on IT systems to upload a brief patient summary which may include:** recent consultations, current diagnosis; past medical history; recent investigations; medication; any other fields which might be helpful to aid triage in secondary care. |