**URGENT REFERRAL FORM FOR**

**ADULT SUSPECTED HAEMATOLOGICAL CANCERS**

(Including Leukaemia, Myeloma, Non-Hodgkin’s &Hodgkin’s Lymphomas)

***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

|  |
| --- |
| **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?**

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

**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.**  | **Hospital 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 ☐  |
| **Malignancy suspected:** **Leukaemia** **☐ Lymphoma (HD or NHL)** **☐ Myeloma** **☐** |
| ***Refer IMMEDIATELY as an EMERGENCY the following patients:******* Patients with a blood count/film reported as acute leukaemia**** Patients with spinal cord compression or renal failure suspected of being caused by myeloma |

|  |
| --- |
| **REFERRAL INFORMATION** |
| **Leukemia**Abnormal FBC indicating leukemia | YES☐ NO☐ | **Myeloma**Protein electrophoresis indicative of myelomaBence-Jones protein suggestive of myeloma | YES☐ NO☐YES☐ NO☐ |
| **Hodgkin’s Lymphoma / Non-Hodgkin’s**Unexplained lymphadenopathy orSplenomegaly with any of the following:FeverNight sweatsShortness of breathPruritusWeight loss | YES☐YES☐ YES☐ YES☐ YES☐ YES☐ | **Hodgkin’s Lymphoma**Alcohol induced lymph node pain | YES☐ NO☐ |
| **Additional Lymphadenopathy features**Lymph nodes increasing in sizeWidespread naturePersistence for 6 weeks or moreLymph nodes greater than 2cm in size | YES☐ NO☐YES☐ NO☐YES☐ NO☐YES☐ NO☐ |  |  |
| **INVESTIGATION RESULTS:** PLEASE ensure that any recent blood results are attached |
| 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 with regards to why you feel this patient may have cancer.** |
| **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. |