**URGENT REFERRAL FORM FOR**

**SUSPECTED LUNG & PLEURAL CANCERS**

(Including Lung and Mesothelioma)

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| **PLEASE NOTE THAT REFERRAL FOR SUSPECTED LUNG AND PLEURAL CANCERS SHOULD BE MADE VIA:**1. **WROCS CXR REQUEST (N.B. IF REPORTED WITH A “LUNG TEAM FLAG” THIS WILL BE TAKEN AS AN AUTOMATIC REFERRAL)**

**OR**1. **WROCS CT SCAN REQUEST (IF CXR IS NORMAL BUT THERE IS STILL CLINICAL SUSPICION)**
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**THIS FORM SHOULD ONLY BE USED TO MAKE AN URGENT REFERRAL IF RADIOLOGICAL IMAGING HAS BEEN COMPLETED ELSEWHERE I.E. HAS NOT BEEN REQUESTED VIA WROCS**

Fax to: 0151 604 7172

Telephone Contact No.: 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?**

**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.**  |  |
| **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****If there is evidence of Superior Vena Cava Obstruction or Stridor REFER AS AN EMERGENCY AND NOT VIA THE URGENT ROUTE!** |
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| • CT suggestive of lung cancer (performed elsewhere) • OtherIf CT performed elsewhere please clarify where this was performed:If other please clarify:  |  |  Yes ☐ No ☐ Yes ☐ No ☐   |  |
| 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 should/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. |