**URGENT REFERRAL FORM FOR**

**SUSPECTED LUNG & PLEURAL CANCERS**

(Including Lung and Mesothelioma)

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

**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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 ☐ | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRAL INFORMATION**  **If there is evidence of Superior Vena Cava Obstruction or Stridor REFER AS AN EMERGENCY AND NOT VIA THE URGENT ROUTE!** | | | |
|  | | | |
| • CT suggestive of lung cancer (performed elsewhere)    • Other  If 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. | | | |