[http://www.wuth.nhs.uk/img/colour_logo.png](http://www.wuth.nhs.uk/)

**REFERRAL FOR SUSPECTED UPPER GASTROINTESTINAL CANCERS**

***and***

**DIRECT TO SCOPE PATIENTS (non-cancer referral, will be done within 6 weeks)**

(Including oesophageal, pancreatic, stomach, gallbladder & liver)

**IMPORTANT NOTES**

1. This if for WUTH patients only
2. Incomplete forms will be returned
3. All patients MUST have a full blood count and eGFR result within the last 3 months
4. Send referrals to [wih-tr.DirectScope@nhs.net](mailto:wih-tr.DirectScope@nhs.net) with the patient name and DOB in the message subject
5. WEIGHT LOSS: NICE guidance recommends a direct to test system for suspected cancers**,** including CT scanning. **CT scans should be arranged in primary care and are recommended for patients with significant weight loss.** Any patient where a CT has been arranged will be offered a clinic appointment after endoscopy.
6. IRON DEFICIENCY ANAEMIA (IDA) falls within colorectal referral guidelines. Patients with IDA should be referred to either the IDA clinic or, if they meet cancer referral guidelines, via the suspected colorectal cancer pathway.

<https://www.nice.org.uk/guidance/ng12/chapter/1-recommendations-organised-by-site-of-cancer#upper-gastrointestinal-tract-cancers>

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| --- | --- |
| **Date of referral:**Click here to enter text. | **Date of Decision to Refer:**Click here to enter text. |

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| **REFERRER DETAILS** | | |
| **NHS No.**Click here to enter text. | **Gender:**Click here to enter text. | **Title:**Click here to enter text. |
| **Surname:**Click here to enter text. | **Forename:**Click here to enter text. | |
| **DOB:** Click here to enter text. |  | |
| Address:Click here to enter text. | **Home tel. no.**Click here to enter text.  **Mobile tel no.**Click here to enter text.  **Preferred contact no.**Click here to enter text.  Overseas or temporary visitor Yes  No | |
| **Practice details** Click here to enter text.  Practice address: Click here to enter text. | GP CodeClick here to enter text.  Referring GPClick here to enter text.  Practice CodeClick here to enter text.  Tel. No.Click here to enter text.  Fax No.Click here to enter text. | |

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| **PERFORMANCE STATUS (please tick one)** | |
| **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 |
| **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 |

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| **PATIENT ENGAGEMENT** | |
| 1. Has the patient been informed about the pathway and why they are being referred? (where applicable) | Yes |
| 1. The patient has been advised that they need to be available within the next two weeks? (where applicable) | Yes |
| 1. Have you ensured that the telephone contact details are correct? | Yes |
| 1. Has the patient been given the 2 week wait information leaflet (where applicable)? | Yes |
| 1. Does the patient have capacity to give consent for gastroscopy?   If no please give contact details of NOK or IMCA | Yes |

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| **CULTURAL, MOBILITY, IMPAIRMENT ISSUES** | |
| Interpreter required Yes  No  Language? Click here to enter text.  Ethnic GroupClick here to enter text.  ReligionClick here to enter text.  Please list any hearing or visual impairments requiring specialist help (Sign language, Braille, Loop Induction systems) Click here to enter text. | Any disability Yes  No  If yes, please specify Click here to enter text.  Does the patient need a hoist? Yes  No  Size: \_\_\_\_\_\_\_\_\_\_\_\_  Transport Required Yes  No  **IT IS THE RESPONSIBILITY OF THE GP TO ARRANGE TRANSPORT** |

**YOU ARE REFERRING FOR A TEST WHICH COMMONLY INCLUDES BIOPSIES. HISTOLOGY RESULTS WILL BE SENT TO THE REFERRING GP**

For patients with confirmed or suspected cancer diagnosed at endoscopy the results will be tracked by the upper GI cancer nurse specialists and the patient informed on return to clinic

For all other diagnoses it is the responsibility of the referring GP to act upon histology results.

A basic guide to interpreting histology is available [here](http://www.wuth.nhs.uk/media/4128785/GP-guide-to-histology.docx)

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| **REASON FOR REFERRAL**  **(PLEASE TICK ONE INDICATION ONLY and complete boxes where needed please)** | | |
|  | **INDICATION** | **WHAT WILL HAPPEN** |
| **A** | **Dysphagia** | Patients with **a performance status of 1, 2 or 3 will be offered an upper GI endoscopy within 2 weeks**  Patients with a **performance status of 4 will be offered a clinic appointment** |
| **B** | **Age 55 and over with weight loss** PLUS  **Reflux** Yes  **Dyspepsia** Yes  At least one must be selected  **Upper abdominal pain** Yes |
| **C** | **People of any age with non-acute haematemesis**  If patients present with acute haematemesis please consider admission |
|  | | |
| **D** | **People aged 55 and over with treatment resistant dyspepsia** | Patients with **a performance status of 1, 2 or 3 will be offered an open access upper GI endoscopy within 6 weeks**  Patients with a **performance status of 4 will be offered a clinic appointment** |
| **E** | **People aged 55 and over with upper abdominal pain with low Hb** |
| **F** | **People aged 55 and over with raised platelets** PLUS  Nausea Yes  Vomiting Yes  Weight loss Yes  Select at least one  Reflux Yes  Dyspepsia Yes  Upper abdominal pain Yes |
| **G** | **People aged 55 and over with nausea and vomiting** PLUS  Weight loss Yes  Reflux Yes  Select at least one  Dyspepsia Yes |
|  | | |
| **H** | **Suspected Pancreatic Cancer** (please include a referral letter)  Patient aged 40 and over with jaundice Yes  Select at least  Abnormal CT or USS suggestive of pancreatic cancer Yes  one | Patients will be seen in clinic **within 2 weeks** |
| **I** | **Suspected Gallbladder Cancer** (please include a referral letter)  Abnormal CT or USS suggestive of gallbladder cancer Yes |
| **J** | **Suspected Liver Cancer** (please include a referral letter)  Abnormal CT or USS suggestive of liver cancer Yes |
| **K** | **Upper abdominal mass consistent with stomach cancer** |

**For patients with significant weight loss the GP should also arrange direct access CT scanning at the time of completing this form (in accordance with NICE guidance)**

**Please tick here to confirm that the CT scan has been arranged** Yes

For patients where there is confirmed evidence the GP has arranged a CT scan, an urgent outpatient appointment with gastroenterology will be offered after endoscopy

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| **CLINCIAL DETAILS AND ADDITIONAL INFORMATION (Details of history, previous investigations)**  **Please include details of any previous endoscopy or barium results here** |
| Click here to enter text. |

**The following conditions will be offered hospital follow up**

Please select here if you DO NOT WANT the hospital to offer follow up

* **Gastric ulcers – (this will normally be via repeat endoscopy)**
* **Severe oesophagitis – (this will normally be via repeat endoscopy)**
* **Barrett’s oesophagus**
* **Oesophageal strictures**
* **Duodenal strictures**
* **Non-inflating stomachs**
* **Any patient where the endoscopist feels CT is indicated on the basis of the endoscopy result**
* **Patients with weight loss where the GP has arranged a CT scan at the point of referral**

Once significant pathology has been excluded, symptoms should be reviewed in primary care in the first instance.

If required, a routine outpatient referral can be made where we will be happy to see the patient and advise on management.

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| **BLOOD RESULTS** | |
| Hb | Click here to enter text. |
| MCV | Click here to enter text. |
| Plts | Click here to enter text. |
| eGFR | Click here to enter text. |

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| **PAST MEDICAL HISTORY (please give details)** | |
| Diabetes mellitus (please tick) | Yes  No  If yes, Diet  Tablet  Insulin |
| Cardiac disease | Yes  No  Click here to enter text. |
| Respiratory disease | Yes  No  Click here to enter text. |
| Implantable cardiac defibrillator | Yes  No |
| Cardiac pacemaker | Yes  No |

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| **MEDICATIONS** | |
| **ANTICOAGULANTS** | |
| Warfarin | Yes  No  If yes, target INR Click here to enter text. |
| Dabigatran | Yes  No |
| Rivaroxaban | Yes  No |
| Apixiban | Yes  No |
| Edoxaban | Yes  No |
| **ANTIPLATELETS** | |
| Clopidogrel | Yes  No |
| Ticagrelor | Yes  No |
| Prasugrel | Yes  No |
| **OTHER**  (please specify) | Yes  No |
| **We can accept a copied list of current all medications.**  **Please place here:** | |

**VETTING** (for hospital use only – complete sections 1 and 2)

**1**

**Book 2 week scope ☐ Book 6 week scope ☐ Nurse suitable? Yes ☐ No ☐**

(Criteria: patients under 85 with performance status 0,1 or 2)

**Book clinic ☐** (Criteria: any patient with performance status 4 OR indications H, I, J, K)

**2 week wait ☐**(A**,** B, C) **6 week wait☐**(D,E,F, G)

**2**

**Also needs clinic appointment after endoscopy? Yes ☐ No ☐**

(Criteria: patients with weight loss where the GP has already arranged a CT)

**For patients booked directly into clinic in section 1, this is not applicable**

**Vetted by: Date:**