**Pan London Suspected Lower GI Cancer Referral Form**

[Press the <Ctrl> key while you click here to view the Pan London COVID-19 Suspected Cancer Referral Support Guide](https://myhealth.london.nhs.uk/wp-content/uploads/2019/04/Pan-London-Suspected-Cancer-Referral-Support-Guide.pdf)

**REFERRAL DATE:** 

**A FIT test result should be requested in conjunction with this referral as it will be used to triage patients to the appropriate investigations within secondary care.**

**This form should be used to refer a patient to their hospital of choice via E-referral (e-RS).**

**ALL suspected cancer referrals MUST be sent via e-RS within 24 hours.**

[Press the <Ctrl> key while you click to view a list of London hospitals](https://myhealth.london.nhs.uk/wp-content/uploads/Lower-GI.html)

Please check on ***e-RS if a hospital can accept the referral*.**

**PATIENT DETAILS**

**SURNAME:**       **FIRST NAME:**       **TITLE:** 

**GENDER:**       **DOB:**        **AGE:****NHS NO:** 

**ETHNICITY:**        **LANGUAGE:** 

**INTERPRETER REQUIRED**  **TRANSPORT REQUIRED**

**PATIENT ADDRESS:**       **POSTCODE:** 

**DAYTIME CONTACT TEL:** 

**HOME TEL:**       **MOBILE TEL:**       **WORK TEL:** 

**EMAIL:** 

**CARER/KEY WORKER DETAILS**

**NAME:**       **CONTACT TELEPHONE:**       **RELATIONSHIP TO PATIENT:** 

**COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT**

**COGNITIVE**   **SENSORY**  **MOBILITY**   **DISABLED ACCESS REQUIRED**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**SAFEGUARDING**

**SAFEGUARDING CONCERNS**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**GP DETAILS**

**USUAL GP NAME:** 

**PRACTICE NAME:**       **PRACTICE CODE:**  

**PRACTICE ADDRESS:** 

**BYPASS TEL:** 

**MAIN TEL:**       **FAX:**       **EMAIL:** 

**REFERRING CLINICIAN:** 

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| **REASON FOR SUSPECTED CANCER REFERRAL:**  [For FAQ on use of FIT in the Lower GI pathway press the <Ctrl> key while you click here](https://www.healthylondon.org/wp-content/uploads/2020/03/Covid-LGI-2WW-FAQ_June-2020-FINAL.pdf) | |
|  | **Abnormal lower GI investigations (colonoscopy/flexible sigmoidoscopy/CT scan) suggestive of cancer (please give full clinical details in the 'additional clinical information' box below)** |
|  | **Positive FIT (Faecal Immunochemical Test) (FIT ≥10) suggestive of cancer (please attach pathology findings to referral form)**  **Negative FIT (FIT is ≤10) but strong clinical suspicion of cancer due to continued symptoms (please complete additional clinical information box at time of referral below)** |
| **Refer patients WITHOUT a FIT test if any of the following:** | |
|  | **Any age with unexplained rectal mass** |
|  | **Any age with unexplained anal mass or unexplained anal ulceration** |
|  | **Patient meets NICE NG12 criteria or there is strong clinical suspicion of colorectal cancer criteria, but a FIT test has NOT been done. Please use the ADDITIONAL CLINICAL INFORMATION box to provide full clinical details of the reasons why you feel they need to be investigated by secondary care and why a FIT test was not performed. You may still be contacted by the hospital to complete a FIT test to aid triage.** |
| **ADDITIONAL CLINICAL INFORMATION:** | |

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| **PRIOR TO REFERRAL INTO SECONDARY CARE** |
| **Offer a FIT test (Faecal Immunochemical Test) before referring to assess for colorectal cancer in adults with abdominal and bowel symptoms. These could include any one or a combination of the following unexplained symptoms:** |
| * **Abdominal mass** * **Rectal bleeding1** * **Change in bowel habit** * **Iron deficiency and non-iron deficiency anaemia** * **Abdominal pain** * **Weight loss** |
| **1Patient should take the sample from a stool when bleeding is not seen**  **PLEASE ONLY REFER PATIENTS URGENTLY IF:**   * **FIT is ≥10** * **RECTAL/ANAL MASS OR ULCERATION** * **FIT is ≤10 WITH CLINICAL CONCERNS OF COLORECTAL CANCER (AS PER NG12 GUIDANCE)**   **PLEASE TICK THE FIT BOX BELOW AND GIVE FULL CLINICAL DETAILS IN THE 'ADDITIONAL CLINICAL INFORMATION' BOX BELOW** |

|  |  |  |
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| **MANDATORY BOX FOR ALL PATIENTS - WHO PERFORMANCE SCORE**  **Enter score to establish if patient is suitable for straight to test CT scan, endoscopy or ultrasound prior to first outpatient appointment** | | |
|  | **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, e.g. light housework, office work.** |
|  | **2** | **Ambulatory and capable of all self-care but unable to carry out any work activities.**  **The patient is 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 out any self-care. The patient is totally confined to bed or chair.** |

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| **SUITABILITY FOR TELEPHONE TRIAGE/STRAIGHT TO TEST ENDOSCOPY PATHWAY.**  **PLEASE COMPLETE THIS SECTION FOR ALL PATIENTS.**  **The following information establishes if the patient is suitable for telephone triage and the ‘straight to test’ endoscopy pathway. All patients must have up to date renal function (within 3 months) as they may be sent for straight to test CT colonography prior to first outpatient appointment.** | |
|  | **Patient has dementia** |
|  | **Patient has learning disability** |
|  | **Patient has physical impairment that prevents patient being ambulant from a wheelchair** |
|  | **Patient has a suspected ANAL PATHOLOGY** |
|  | **Patient is on anticoagulant or antiplatelet agents (except aspirin)** |
|  | **Digital rectal examination has been performed (please include findings both positive and negative in ‘additional clinical information’ box below)** |
|  | **Patient has had other gastrointestinal investigations in the last 12 months (abdominal imaging or gastrointestinal endoscopy). Please ensure relevant details are included in the ‘imaging studies/endoscopy studies’ boxes below including name of specialist and hospital where the investigations were performed** |
|  | **Patient is unsuitable for telephone triage. If so please give reasons:** |

**Personal/relevant patient information:**

**Past history of cancer:**

**Relevant family history of cancer:**

|  |  |
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|  | **I have discussed the possible diagnosis of cancer with the patient** |
|  | **The patient has been advised that they will be contacted by the hospital by telephone** |
|  | **I have advised patient that they should prioritise this appointment. I have offered the pan London COVID -19 patient information leaflet. Offering written patient information increases patient experience and reduces non-attendance. These are available in 11 different languages.**  [Press the <Ctrl> key while you click here to view the leaflet](https://www.healthylondon.org/resource/covid-19-cancer-referral-resources/)  [Press the <Ctrl> key while you click here to view a specific patient leaflet](https://www.healthylondon.org/wp-content/uploads/2020/03/COVID-19-Urgent-Suspected-Bowel-Cancer-Patient-Information-Final.pdf) on Lower GI referral referrals |
|  | **This patient has been added to the practice suspected cancer safety-netting system**  [Press <Ctrl> key + click here to view Pan London Practice-based Suspected Cancer Safety Netting System](https://www.healthylondon.org/wp-content/uploads/2020/04/Key-safety-netting-messages-during-Covid-19-pandemic-Final-version-9th-April-2020-003.pdf) |

**INVESTIGATIONS**

**Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.**

**QUANTITIVE FAECAL IMMUNOCHEMICAL TEST (all recorded values)**

**ENDOSCOPY STUDIES (in past year) Please include date:** **and location:** 

**IMAGING STUDIES (in past year) Please include date:**       **and location:**

**CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA**

**RENAL FUNCTION (most recent recorded in past 6 months)**

**FULL BLOOD COUNT (most recent recorded in past 6 months)**

**IRON STUDIES (most recent recorded in past 6 months)**

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**