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

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

**REFERRAL DATE:** 

**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/Upper-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 TEL:**       **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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| **GUIDANCE FOR DIRECT ACCESS DIAGNOSTICS**  **Guidance relating to direct access diagnostics investigations including NON URGENT can be found here** [[Press the <Ctrl> key while you click here to view Pan London Suspected Upper GI Cancer Referral Guide](https://www.healthylondon.org/wp-content/uploads/2017/11/Pan-London-Suspected-Cancer-Referral-Guide-Upper-GI.pdf)](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/guides/uppergi) |
| **REASON FOR SUSPECTED CANCER REFERRAL** |
| **OESOPHAGUS/STOMACH**  **Gastrointestinal endoscopy suggestive of oesophageal or stomach cancer**  **Dysphagia**  **Upper abdominal mass consistent with stomach cancer**  **Age ≥55 with weight loss AND any one of the following (please specify):**  **Reflux**  **Upper abdominal pain**  **Dyspepsia** |
| **PANCREAS, LIVER, GALLBLADDER**  **Abdominal CT/MRI/ultrasound scan suggestive of pancreatic, liver or gallbladder cancer**  **Age ≥ 40 with Jaundice**  **Upper abdominal mass consistent with an enlarged liver**  **Upper abdominal mass consistent with an enlarged gall bladder**  **Age ≥60 with weight loss and any one of the following (please specify):**  **Abdominal pain**  **Back pain**  **Diarrhoea**  **New onset diabetes**  **Constipation**   **Vomiting**  **Nausea** |
| **Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP MUST give full clinical details in the ‘additional clinical information’ box at time of referral)** |

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| **ADDITIONAL CLINICAL INFORMATION:** |

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| **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.** |

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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 prior to first outpatient appointment.**  **Y**  **N**  **Patient has dementia**  **Y**  **N**  **Patient has learning disability**  **Y**  **N**  **Patient has physical impairment that prevents patient being ambulant from a wheelchair**  **Y**  **N**  **Patient is on anticoagulant or antiplatelet agents (except aspirin)**  **Y**  **N**  **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**  **Y**  **N**  **Patient is unsuitable for telephone triage. If so, please give reasons:** |

**Anticoagulant status and reason:**

**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 and confirmed that they will be available for an urgent 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 covid-19 Cancer Referral Resources page](https://www.healthylondon.org/resource/covid-19-cancer-referral-resources/)  **I have informed the patient that they might be called for an investigation (endoscopy and/or CT MRI) prior to having a clinic/telephone appointment**  **Referral is due to GP not having direct access to relevant investigations**  **The patient has been added to the practice suspected cancer safety netting system**  [Press the <Ctrl> key while you 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) |

**CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA**

**IMAGING STUDIES (in past 6 months) Please include date:**       **and location:**      

**PREVIOUS GASTROSCOPY (within 12 months)**

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

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

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

**HBA1C (most recent recorded in past 6 months)**

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**

**OFFICE USE ONLY**