**Suspected Bladder and Renal (Urological) Cancer Referral Form**

**Cancer 2 Week Wait Referral**

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| **Referrer Details**  | **Patient Details**  |
| Name: | Name: | DoB: |
| Address: | Address: | Gender: |
| Hospital No.: |
| NHS No.: |
| Tel No: | Tel No. (1): | *Please check tel. nos.* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning difficulties)? | Capacity concerns? |
|  Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | Mobility:  |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |
| Please confirm that the patient is aware that this is a suspected cancer referral and that the two week wait referral leaflet has been given:[ ] Yes [ ] No |
| Date(s) that patient is unable to attend within the next two weeks*If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

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| **Clinical details***Please detail your conclusions and what needs excluding or attach referral letter.* |

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| **Bladder and Renal cancer*****Aged 45 and over*** and have:[ ]  unexplained visible haematuria without urinary tract infection ***or***[ ]  visible haematuria that persists or recurs after successful treatment of urinary tract infection, or[ ]  ***Aged 60 and over*** and have unexplained non-visible haematuria with dysuria[ ]  ***Aged 60 and over*** and have unexplained non-visible haematuria with a raised white cell count on a blood test.**Please provide: FBC(< 8 weeks old)**[ ]  A soft tissue mass identified on imaging thought to arise from the urinary tract.**Please provide: FBC, U&E (including creatinine and eGFR), US, CT, MRI(< 8 weeks old)** |
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| **Smoking status** | **WHO Performance Status:** [ ]  **0** Fully active[ ]  **1** Able to carry out light work[ ]  **2** Up & about 50% of waking time[ ]  **3** Limited self care, confined to bed/chair 50%[ ]  **4** No self care, confined to bed/chair 100% |
| **BMI if available** |

**Please attach additional clinical issues list from your practice system**

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| **Details to include**Current Medication, significant issues, allergies, relevant family history, smoking & alcohol status and morbidities |

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| **Trust Specific Details** |

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| ***For hospital to complete*** UBRN: Received date: |

Please send via **ERS**