**Suspected Lower GI Cancer Two Week Wait Referral Form**

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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 telephone numbers* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning difficulties)? | Capacity concerns? |
| Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | Mobility: |

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| **Level of Concern***I think it is likely that this patient has cancer, and would like the patient to be investigated further even if the first test proves negative, including a Consultant to Consultant referral if deemed appropriate. All non-site specific symptoms (e.g. iron deficiency anaemia, unexplained weight loss) are listed in the clinical details section below.***Clinical details***Please detail your conclusions and what needs to be excluded or attach a referral letter.* |

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| **Colorectal cancer**[ ]  ***Aged 40 and over*** with unexplained weight loss and abdominal pain[ ]  ***Aged*** **under** ***50*** with rectal bleeding **and** any of the following unexplained symptoms or findings: [ ]  abdominal pain [ ]  change in bowel habit [ ]  weight loss [ ]  iron-deficiency anaemia without obvious cause (HB<10.5 and/or ferritin <18mg/l in men and <10 in postmenopausal women)**[ ]  Aged 50 and over** with unexplained rectal bleeding [ ]  ***Aged 60 and over*** with: [ ]  changes in their bowel habit ***or*** [ ]  iron-deficiency anaemia without obvious cause (HB<10.5 and/or ferritin <18mg/l in men and <10 in postmenopausal women) ***or*** [ ]  tests show occult blood in their faeces [ ]  rectal or abdominal (but not pelvic) mass.[ ]  **Positive FIT Test**  [ ]  Aged over 50 with unexplained abdominal pain or weight loss [ ]  Aged 50 to 60 with changes in bowel habit or iron-deficiency anaemia [ ]  Aged 60 or over with anaemia without iron-deficiency **FIT Value µg/** |
| **Anal cancer**[ ]  unexplained anal mass or unexplained anal ulceration |
| **Information required to book patient into the right type of appointment*** Due to Frailty/Old Age/ Co-morbidity, does the patient require an OPA for assessment before tx? [ ]
* Is the patient **fit** for bowel preparation/endoscopy and **willing** to undergo this type of procedure[ ]  Yes [ ]  No
* Please confirm that the following results are available:
	+ Ferritin, Stool sample, FBC, Hb, U & E, - within last 8 weeks
	+ Renal function including eGFR - within the last 4 weeks
* Has the patient had previous bowel cancer or related surgery? [ ]  Yes [ ]  No
* Is the patient on Warfarin/Clopidogrel? [ ]  Yes [ ]  No
* Is the patient diabetic? [ ]  Yes [ ]  No
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| **Smoking status** | **WHO Performance Status:** [ ]  **0** Fully active[ ]  **1** Able to carry out light work[ ]  **2** Up & about greater than 50% of waking time[ ]  **3** Confined to bed/chair greater than 50%[ ]  **4** Confined to bed/chair 100% |
| **BMI if available** |

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| Please confirm that the patient has been made aware that this is a suspected cancer referral: [ ] Yes [ ] NoPlease confirm that the patient has received the two week wait referral leaflet: [ ] Yes [ ] NoPlease provide an explanation if the above information has not been given:If your patient is found to have cancer, do you have any information which might be useful for secondary care regarding their likely reaction to the diagnosis (e.g. a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological or emotional readiness for further investigation and treatment? |
| 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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| **Please attach additional clinical issues list from your practice system****Details to include:**Current Medication, significant issues, allergies, relevant family history, 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 e-RS

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| Name:     Address:      Date of Birth:      Hospital Number:      |
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| Procedure:Colonoscopy [ ]  Barium Enema [ ]  Small Bowel Meal[ ]  CTC [ ]  Capsule Study [ ]  Other       |
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| Step 1: Absolute ContraindicationsGI Obstruction, ileus or perforation Severe Inflammatory Bowel Disease Toxic Megacolon Reduced conscious level Hypersensitivity to any ingredients Dysphagia (unless via NGT) Ileostomy  |          |
|  If yes to any question, do not continue  |
| Step 2: If patient likely to have abnormal blood test -  Review the Blood results |
| Na       K      eGFR       | eGFR 30-60 = CKD 3eGFR 15-29 = CKD 4eGFR 0-14 = CKD 5 |
|  If abnormal blood results, refer to Step 4 |
| Step 3: Review Medications |
| ACEi/ARB |  | Safe to stop for 72 hrs? |  |
| Diuretics |  | Safe to stop for 24 hrs? |  |
| NSAIDs |  | Safe to stop for 72 hrs? |  |
| Lithium\* |  | Safe to stop? |  |

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| Oral Bowel Cleansing Agent Prescription Checklist This checklist is to be completed by the referring clinician and a copy should then be filed in the patient’s medical records. |
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| Step 4: Consider Co-Morbidities & Risk Factors |
| Co-Morbidities | Optimal Bowel Cleansing | Acceptable |
| Kidney DiseaseCKD 3CKD 4CKD 5HaemodialysisPeritoneal DialysisRenal TransplantElectrolyte ImbalanceCardiac FailureLiver CirrhosisHypertension | Klean Prep / PicolaxKlean Prep (if fluid status allows)Klean Prep (if fluid status allows)Discuss with nephrologistDiscuss with nephrologistDiscuss with nephrologistKlean PrepKlean PrepKlean PrepKlean Prep / Picolax | PicolaxPicolaxPicolaxPicolaxPicolaxPicolax |
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| Step 5: Other Comments: |
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| Step 6: Type of Bowel Prep to be Issued: Picolax / Klean Prep(Picolax is the bowel cleansing solution of choice for most patients) |
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| Step 7: Instructions provided to patient  |
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| Step 8: Signature..............................................................................Print Name      Designation       Date      |