**Suspected Lung Cancer 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 tel. nos.* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning disabilities)? | Capacity concerns? |
|  Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | Mobility: |

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| **Level of concern** □*“I’m pretty sure my patient has cancer”*□ *“I’m unsure, it might well be cancer but there are other equally plausible explanations.”*□ *“I don’t think my patient has cancer but I would like to rule it out.”*□ *“Doesn’t meet criteria but I have a cancer concern”***Clinical details***Please detail your conclusions and what needs excluding or attach referral letter.*[ ]  Patient on anticoagulants (please specify which)       |

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| Lung cancer or mesothelioma[ ] have chest X‑ray findings that suggest lung cancer or mesothelioma (location of x-ray      )***Chest X-ray should be no more than 3 weeks old***[ ] are aged 40 and over with [unexplained](http://www.nice.org.uk/guidance/NG12/chapter/terms-used-in-this-guideline#terms-used-in-this-guideline) haemoptysis***Please arrange a chest X-ray to take place in next 48 hours***For minor or resolved haemoptysis without other symptoms suggestive of lung cancer, consider just a chest X-ray[ ] have a normal chest X-ray but with a high index of suspicionUp to 25% of chest X-rays can be falsely negative in lung cancer so if the clinical suspicion is high or there is clinical lymphadenopathy or clubbing, refer urgently to lung cancer service.Has patient had a recent CT scan?[ ]  Yes (please give location of scan      )[ ]  No, please arrange this [ ]  No, but I have requested one (ideally refer to same hospital as scan) |
| **Please ensure the following recent blood results are available (less than 8 weeks old)**FBC, eGFR, clotting, U&E,LFT, bone profileLung Function if availableFEV1 \_\_\_\_% predicted \_\_\_\_**Anticoagulation**Please provide details and latest INR |

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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** |

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| 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*For patients to be managed in a timely way to any eventual treatment, we aim to see them within 10 days of receiving this referral. Please ensure the patient understands this expectation and the clinical importance of making themselves available for urgent assessment.* |

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

# Please send via e-RS