**Suspected Testicular (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 telephone numbers* | |
| Tel No. (2): | | | |
| Email: | Carer requirements (has dementia or learning difficulties)? | | | | Capacity concerns? | |
| Decision to Refer Date: | Translator Required: YesNo Language: | | | | Mobility: | |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

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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  *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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| **Testicular cancer**  non-painful enlargement or change in shape or texture of the testis (consider).  **Please provide: FBC, U&E, α-FP, β-HCG, LDH (< 8 weeks old)**  *If swelling is clearly separate from Testis on examination, it is unlikely to be a testicular tumour. Consider ultrasound before referral. Always perform transillumination to exclude benign epididymal cyst(s). Consider a direct access ultrasound scan for a scrotal mass that does not transilluminate or when the body of the testis cannot be easily distinguished on examination (e.g. large hydrocele).* |
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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**