**Suspected Upper Gastrointestinal Tract Cancers 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: Yes[ ] No [ ] Language: | Mobility: |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

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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.* |

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| **Gall bladder cancer**[ ]  ultrasound indicates gall bladder cancer |
| **Liver cancer**[ ]  ultrasound indicates liver cancer |
| **Oesophageal Cancer***All NICE recommendations are for direct access upper GI endoscopy* |
| **Pancreatic cancer**[ ] aged 40 and over and have jaundice;[ ]  CT indicates pancreatic cancer;[ ]  ultrasound indicates pancreatic cancer. |
| **Stomach cancer**[ ] upper abdominal mass consistent with stomach cancer (consider) |
| **Please ensure the following recent blood results are available (less than 8 weeks old)**FBC, Hb, LFT, MCV, Ferritin, Iron studies, U&E, bilirubin. CA19-9 |

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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*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.* |

**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**