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

**Please complete all elements of this form, including the completion of a FIT test prior to 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: |

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|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

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| **FIT test prior to referral**  As per cancer alliance and ICB endorsement,and in line with new national guidance to GPs**, *all patients should undertake a FIT test prior to referral on this pathway,*** unless presenting with **anal mass/ulceration** OR **abdominal/rectal mass** OR **Iron Deficiency Anaemia** (consider TTG/faecal calprotectin in younger patients and menorrhagia in menstruating patients prior to referral on this pathway).  Please await the **result of the FIT test** **before** referring, unless agreed via Advice and Guidance with a Consultant via[sft.salisburycolorectaladvice@nhs.net](mailto:sft.salisburycolorectaladvice@nhs.net)  **FIT Value ……….** μg  Patient has a FIT value of ≥ 10 μg Hb/g faeces; positive FIT  Patient unable to undertake qFIT (pls complete Frailty below and outline reason in Clinical Details section)  If the patient has a negative FIT value of <10μg Hb/g, please do NOT refer the patient via a 2ww pathway unless you have sought advice and guidance from a secondary care clinician, or the patient has progressive or alarming symptoms on subsequent review, which are defined in the clinical details.  Please also consider repeating qFIT at 4-6 week (patients with two negative FIT test results have a colorectal cancer risk of <0.04%) |

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| **Clinical details**  *Please detail your conclusions and what needs to be excluded or attach a referral letter.* |

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| **Colorectal cancer – PLEASE TICK ALL RELEVANT BOXES**  Unexplained weight loss and FIT ≥ 10  Unexplained abdominal pain and FIT ≥ 10  Change in bowel habit and FIT ≥ 10  Overt rectal bleeding and FIT ≥ 10  Non-iron deficiency anaemia and FIT ≥ 10  Iron Deficiency Anaemia  Palpable abdominal mass  Palpable rectal mass on PR | |
| **Anal cancer**  Unexplained anal mass or unexplained anal ulceration | |
| **Information required to book patient into the right type of appointment (*which is essential to allow the majority of patients to progress quicker via ‘straight to test’ and reduce patient harm*)**   * Due to Frailty/Old Age/ Co-morbidity, the patient requires an OPA for assessment before diagnostics? * Is the patient likely **fit** for bowel preparation/endoscopy and **willing** to undergo this type of procedure  Yes  No * Please confirm that the following results are available:   + Ferritin, FBC, Hb - ***within last 8 weeks***   + Renal function including eGFR - ***within the last 8 weeks*** * Has the patient had previous bowel cancer or related surgery?  Yes  No * Are you aware of the patient having an allergy to iodine/contrast medium (e.g. Gastrograffin, Primovist)?  Yes  No * Is the patient diabetic?  Yes  No   Complete below *where not fully detailed/included* when form auto-populates re current medications:   * Is the patient on any Anticoagulant or Antiplatelet agents?  Yes  No * Is the patient on any ACEi/ARB?  Yes  No * Is the patient on any diuretics?  Yes  No * Is the patient on any NSAIDs?  Yes  No * Is the patient on Lithium?  Yes  No   Do you consider it safe for the patient to stop all above medications for a period of up to 72 hours?  Yes  No  If no, please provide further detail below | |
| **Smoking status** | **Height/Weight/BMI if available** |
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| ***PLEASE TICK AS APPROPRIATE- THIS MUST BE COMPLETED AS IT IS ESSENTIAL TO ALLOW THE MAJORITY OF PATIENTS TO PROGRESS QUICKER VIA ‘STRAIGHT TO TEST’*** |
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| Please confirm that the patient has been made aware that this is a suspected cancer referral: Yes No  Please confirm that the patient has received the two-week wait referral leaflet: Yes No  Please confirm whether the patient has had a previous bowel investigation in the last 2 years: Yes No  If yes, please state what investigation has been performed:  Colonoscopy  Flexi sigmoidoscopy  CT Colonography  Please 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:**  Contraindications, current medication, significant issues, allergies, relevant family history, alcohol status and morbidities |

Please send **via ERS**