**Suspected Bladder and Renal (Urological) Cancer Referral Form**

**Cancer 2 Week Wait Referral**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 difficulties)? | | | | Capacity concerns? | | |
| Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | | | | Mobility: | | |
|  | Military Service Person |  | Military Veteran | |  | Member of Military Family |
| 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.* | | | | | | | |

|  |
| --- |
| **Clinical details**  *Please detail your conclusions and what needs excluding or attach referral letter.* |

|  |
| --- |
|  |
| **Bladder and Renal cancer**  ***Aged 45 and over*** and have:  unexplained visible haematuria without urinary tract infection ***or***  visible haematuria that persists or recurs after successful treatment of urinary tract infection, or  ***Aged 60 and over*** and have unexplained non-visible haematuria with dysuria  ***Aged 60 and over*** and have unexplained non-visible haematuria with a raised white cell count on a blood test.  **Please provide: FBC(< 8 weeks old)**  A soft tissue mass identified on imaging thought to arise from the urinary tract.  **Please provide: FBC, U&E (including creatinine and eGFR), US, CT, MRI(< 8 weeks old)** |
|  |
|  |

|  |  |
| --- | --- |
| **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**

|  |
| --- |
| **Details to include**  Current Medication, significant issues, allergies, relevant family history, smoking & alcohol status and morbidities |

|  |
| --- |
| **Trust Specific Details** |

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

Please send via **ERS**