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

|  |  |  |
| --- | --- | --- |
| **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: |

|  |
| --- |
| **Level of Concern**  *I think it is likely that this patient has cancer, and would like the patient to be investigated further even if the first test proves negative, including a Consultant to Consultant referral if deemed appropriate. All non-site specific symptoms (e.g. iron deficiency anaemia, unexplained weight loss) are listed in the clinical details section below.*  **Clinical details**  *Please detail your conclusions and what needs to be excluded or attach a referral letter.* |

|  |  |
| --- | --- |
| **Colorectal cancer**  ***Aged 40 and over*** with unexplained weight loss and abdominal pain  ***Aged*** **under** ***50*** with rectal bleeding **and** any of the following unexplained symptoms or findings:  abdominal pain  change in bowel habit  weight loss  iron-deficiency anaemia without obvious cause (HB<10.5 and/or ferritin <18mg/l in men and <10 in postmenopausal women)  **Aged 50 and over** with unexplained rectal bleeding  ***Aged 60 and over*** with:  changes in their bowel habit ***or***  iron-deficiency anaemia without obvious cause (HB<10.5 and/or ferritin <18mg/l in men and <10 in postmenopausal women) ***or***  tests show occult blood in their faeces  rectal or abdominal (but not pelvic) mass.  **Positive FIT Test**  Aged over 50 with unexplained abdominal pain or weight loss  Aged 50 to 60 with changes in bowel habit or iron-deficiency anaemia  Aged 60 or over with anaemia without iron-deficiency  **FIT Value µg/** | |
| **Anal cancer**  unexplained anal mass or unexplained anal ulceration | |
| **Information required to book patient into the right type of appointment**   * Due to Frailty/Old Age/ Co-morbidity, does the patient require an OPA for assessment before tx? * Is the patient **fit** for bowel preparation/endoscopy and **willing** to undergo this type of procedure  Yes  No * Please confirm that the following results are available:   + Ferritin, Stool sample, FBC, Hb, U & E, - within last 8 weeks   + Renal function including eGFR - within the last 4 weeks * Has the patient had previous bowel cancer or related surgery?  Yes  No * Is the patient on Warfarin/Clopidogrel?  Yes  No * Is the patient diabetic?  Yes  No | |
| **Smoking status** | **WHO Performance Status:**  **0** Fully active  **1** Able to carry out light work  **2** Up & about greater than 50% of waking time  **3** Confined to bed/chair greater than 50%  **4** Confined to bed/chair 100% |
| **BMI if available** |

|  |
| --- |
| 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 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.* |

|  |
| --- |
| **Please attach additional clinical issues list from your practice system**  **Details to include:**  Current Medication, significant issues, allergies, relevant family history, alcohol status and morbidities |

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

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

# Please send via e-RS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name:  Address:  Date of Birth:  Hospital Number: | | | | | |
|  | | | | | |
| Procedure:  Colonoscopy  Barium Enema  Small Bowel Meal  CTC  Capsule Study  Other | | | | | |
|  | | | | | |
| Step 1: Absolute Contraindications  GI Obstruction, ileus or perforation  Severe Inflammatory Bowel Disease  Toxic Megacolon  Reduced conscious level  Hypersensitivity to any ingredients  Dysphagia (unless via NGT)  Ileostomy | | | |  | |
| If yes to any question, do not continue | | | | | |
| Step 2: If patient likely to have abnormal blood test -  Review the Blood results | | | | | |
| Na  K  eGFR | | | eGFR 30-60 = CKD 3  eGFR 15-29 = CKD 4  eGFR 0-14 = CKD 5 | | |
| If abnormal blood results, refer to Step 4 | | | | | |
| Step 3: Review Medications | | | | | |
| ACEi/ARB |  | Safe to stop for 72 hrs? | | |  |
| Diuretics |  | Safe to stop for 24 hrs? | | |  |
| NSAIDs |  | Safe to stop for 72 hrs? | | |  |
| Lithium\* |  | Safe to stop? | | |  |

|  |  |  |
| --- | --- | --- |
| Oral Bowel Cleansing Agent Prescription Checklist  This checklist is to be completed by the referring clinician and a copy should then be filed in the patient’s medical records. | | |
|  | | |
| Step 4: Consider Co-Morbidities & Risk Factors | | |
| Co-Morbidities | Optimal Bowel Cleansing | Acceptable |
| Kidney Disease  CKD 3  CKD 4  CKD 5  Haemodialysis  Peritoneal Dialysis  Renal Transplant  Electrolyte Imbalance  Cardiac Failure  Liver Cirrhosis  Hypertension | Klean Prep / Picolax  Klean Prep (if fluid status allows)  Klean Prep (if fluid status allows)  Discuss with nephrologist  Discuss with nephrologist  Discuss with nephrologist  Klean Prep  Klean Prep  Klean Prep  Klean Prep / Picolax | Picolax  Picolax  Picolax  Picolax  Picolax  Picolax |
|  | | |
| Step 5: Other Comments: | | |
|  | | |
| Step 6: Type of Bowel Prep to be Issued: Picolax / Klean Prep  (Picolax is the bowel cleansing solution of choice for most patients) | | |
|  | | |
| Step 7: Instructions provided to patient | | |
|  | | |
| Step 8: Signature..............................................................................  Print Name  Designation       Date | | |