**Suspected Urological (Penile) 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 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.* |

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

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| **Penile cancer**[ ]  penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded as a cause (consider)*This includes progressive ulceration or a mass particularly in the glans penis or prepuce, but can involve the skin of the penile shaft. Lumps within the corpora cavernosa not involving the penile skin are usually not cancer but indicate benign Peyronie’s disease, which does not require urgent or fast track referral.*[ ]  a persistent penile lesion after treatment for a sexually transmitted infection has been completed (consider)[ ]  unexplained or persistent symptoms affecting the foreskin or glans (consider).*This does not include simple phimosis, fungal infections and balanoposthitis.* |

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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**