|  |  |
| --- | --- |
| Date Decision to Refer:  | Referred By:  |

|  |  |
| --- | --- |
| Name:  | DOB:  |
| Address:  | NHS Number: |
| Hospital Number: |
| Home Tel Number: | Mobile Tel Number: |
| Next of Kin or Carer details: Name: Contact number: | Sex assigned at birth:Gender Identity (if different from above): |
| Ethnicity: | Translator Required: Yes 🞏 No 🞏 Language:  |
| Disability: Yes 🞏 No 🞏 Please provide details:  | Capacity concerns: Yes 🞏 No 🞏 Please provide details:  |
| Registered GP Name:  | GP Practice Name:  |
| Surgery Contact Number:  | Surgery Address:  |
| Surgery Bypass Number: | GP email address: |
| Military Service Person 🞏  | Member of Military Family 🞏  | Military Veteran 🞏  |

|  |  |
| --- | --- |
| Has the patient been informed of suspected colorectal cancer referral? | Yes 🞏 No 🞏  |
| Has the patient has received suspected cancer referral leaflet?  | Yes 🞏 No 🞏  |
| Please confirm you have performed a physical exam inc. digital rectal exam on this patient prior to referral. If not, why not? | Yes 🞏 No 🞏  |
| Has the patient had previous bowel investigations in the last 2 years?If yes, please specify what investigation and relevant findings:   | Yes 🞏 No 🞏 Colonoscopy 🞏 Flexi Sigmoidoscopy 🞏 CT Colonography 🞏  |
| If your patient is found to have cancer, do you have any information which might be useful 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? | Yes 🞏 No 🞏 Please provide details: |
| Date(s) that patient is unable to attend within the next two weeks? | Please provide details: |

|  |
| --- |
| **ALL patients should undertake a FIT test prior to referral on this pathway,** unless presenting with **anal mass/ulceration,** **abdominal mass, rectal mass,** OR **Iron Deficiency Anaemia.** Please await the **result of the FIT test** **before** referring, unless agreed via Advice and Guidance onCinapsis **If the patient has Iron Deficiency Anaemia (IDA), please refer to the dedicated IDA service (hyperlink to form)** |
| **FIT Value ……………………….ug/ml** |
| **Please tick all that apply and provide further information:** |
| Unexplained weight loss and FIT ≥ 10  |  | Please specify amount loss and over how long: |
| Unexplained abdominal pain and FIT ≥ 10 |  | Please specify location, duration, characteristics:  |
| Change in bowel habit and FIT ≥ 10 |  | Please specify how bowels have changed: |
| Overt rectal bleeding and FIT ≥ 10 |  | Please provide characteristics:  |
| Non-iron deficiency anaemia and FIT ≥10 |  | Any further information:  |
| Palpable abdominal mass |  | Please specify location, size, and characteristics: |
| Palpable rectal mass on DRE  |  | Please provide further information: |
| Unexplained anal mass or anal ulceration  |  | Please provide further information:  |
| **Clinical details**Please detail your conclusions and what needs to be excluded or attach a referral letter. Please also include your physical examination findings including rectal examination. *(This will allow patients to follow a straight to test pathway).* |

|  |  |
| --- | --- |
| Is the patient on Anticoagulants 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 🞏  |
| Safe to stop **all** the above medication for 72hrs?  | Yes 🞏 No 🞏  |
| Are you aware of the patient having an allergy to iodine/contrast medium (e.g. Gastrograffin, Primovist)?  | Yes 🞏 No 🞏  |
| Is the patient fit for bowel preparation/endoscopy and willing to undergo this type of procedure? | Yes 🞏 No 🞏  |

**WHO Performance Status:**

|  |  |
| --- | --- |
|  0 ☐ | Fully active |
|  1 ☐ | Restricted in physically strenuous activity but ambulatory and able to carry out light work |
|  2 ☐ | Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours |
|  3 ☐ | Capable of only limited self-care, confined to bed/chair 50% of waking hours |
|  4 ☐ | No self-care, confined to bed/chair 100% |

|  |  |
| --- | --- |
| Significant Family History of Colorectal cancer | Yes 🞏 No 🞏 Please provide details:  |
| Significant Medical History (including cancer history) | *Auto populate from GP record* |
| Regular Medication | *Auto populate from GP record* |
| Allergies | *Auto populate from GP record* |
| Alcohol Intake | *Auto populate from GP record* |
| Smoking Status | *Auto populate from GP record* |
| Height, Weight, and BMI | *Auto populate from GP record* |

|  |
| --- |
| **Please ensure bloods are dated within than 4 -6 weeks of referral date** |
| FBC | *Auto populate from GP record* |
| U&E’s | *Auto populate from GP record* |
| LFT’s | *Auto populate from GP record* |
| Iron Studies | *Auto populate from GP record* |
| Clotting | *Auto populate from GP record* |
| GP has reviewed all results | Yes 🞏 No 🞏  |