**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**

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

|  |
| --- |
| **FIT test prior to referral**As per cancer alliance and CCG endorsement, ***all patients should undertake a FIT test prior to referral*** unless presenting with abdominal or rectal mass, overt rectal bleeding, anal ulceration or if they are ≥60 y with iron deficiency anaemia (see FIT test form for further information).**Please await the result of the FIT test before referring.****FIT Value** μg[ ]  Patient has a FIT value of ≥ 10 μg Hb/g faeces; positive FITIf 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.  |

|  |
| --- |
| **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 – PLEASE TICK ALL RELEVANT BOXES*****Any age***[ ]  Abdominal or rectal mass on examination[ ]  Significant comorbidity/eGFR below 40[ ]  Altered blood PR or blood mixed with stool[ ]  Previous bowel cancer[ ]  Positive FIT with **NO** other symptoms given[ ]  Overt rectal bleeding[ ]  **with** change in bowel habit [ ]  **without** change in bowel habit***Aged under 40*** [ ]  Any **TWO** colorectal symptoms e.g. unexplained weight loss, abdominal pain [ ]  Iron deficiency anaemia [ ]  Overt rectal bleeding +/- change in bowel habit***Aged 40 and over*** [ ]  **ISOLATED** weight loss / abdominal pain[ ]  Iron deficiency anaemia [ ]  **with** overt GI bleeding[ ]  **without** GI bleeding [ ]  Change in bowel habit **and** FIT positive[ ]  **with** unexplainedweight loss [ ]  **without** unexplained weight loss[ ]  Tenesmus +/- constipation **and any other GI** symptom***Aged 60 and over***  [ ]  anaemia in the absence of iron deficiency **AND positive FIT** |
| **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 diagnostics? [ ]
* 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 allergic to iodine/contrast medium (e.g. Gastrograffin, Primovist)? [ ]  Yes [ ]  No
* 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
* Is the patient diabetic? [ ]  Yes [ ]  No

Is it safe for the patient to stop all the above medications for a period of 72 hours? [ ]  Yes [ ]  No If no, please provide further detail below**PLEASE NOTE: To reduce risk of patient harm, up to date bloods are required in order to progress referral. The patient’s pathway will be delayed if this information is not provided** |
| **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 [ ] NoPlease confirm that the patient has received the two week wait referral leaflet: [ ] Yes [ ] NoPlease confirm whether the patient has had a previous bowel investigation in the last 2 years: [ ] Yes [ ] NoIf yes, please state what investigation has been performed:  [ ]  Colonoscopy [ ]  Flexi sigmoidoscopy [ ]  CT ColonographyPlease 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:**Contraindications, current cedication, significant issues, allergies, relevant family history, alcohol status and morbidities |

# Please send via e-RS