**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**

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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 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: |

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| **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 FIT  If 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. |

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| **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.* |

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| **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** |

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| 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 confirm whether the patient has had a previous bowel investigation in the last 2 years: Yes No  If yes, please state what investigation has been performed:  Colonoscopy  Flexi sigmoidoscopy  CT Colonography  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* |

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| **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