Please **send via eRS**  to

2 ww Suspected Cancer RAS Respiratory

or

**if eRS is not available for more than 24 hours, email** to [ruh-tr.CancerReferrals@nhs.net](mailto:ruh-tr.CancerReferrals@nhs.net)

**\* All shaded fields are mandatory – please note failure to complete all sections will result in a delay in processing this referral**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section 1: Patient Information**  **(**Please complete in BLOCK CAPITALS) | | | | **Section 2: Practice Information**  (Please use practice stamp if available) |
| Surname: | | | | Date of Referral: / / |
| First Name: | Mr Miss Mrs Ms  Other | | | Referring GP: |
| Date of Birth: / / | | M { } F { } | | Locum? Y { } N { } |
| Address:  Post code: | | | | Practice Address:  Post code: |
| Day time phone: | Mobile phone: | | | e-mail address: |
| Ethnicity? | Language? | | | Telephone: |
| Interpreter?  Y { } N { } | Transport?  Y { } N { } | | | Fax: |
| **Section 3: Clinical History**  Please outline reason for suspecting lung cancer.  Include significant past history, recent blood test results or other relevant information.  Please enclose print outs of CURRENT medications. Is the patient on an **Anticoagulant**? | | | | |
|  | | | | |
| **Section 4: Referral Monitoring Information** | | | | |
| Please confirm that the patient has been informed that they have been referred with suspected lung cancer? Y { } | | | | |
| **Section 5: Clinical Information, patients must meet one or more of the following criteria.**  (Please tick all applicable entries) | | | | |
| { } Persistent haemoptysis (in smokers or ex-smokers 40 years or older)  { } Chest X-Ray suggestive of lung cancer (incl pleural effusion and slowly resolving consolidation) | | | | |
| **Section 6: Performance Status** | | | | |
| { } **0** – Able to carry out all normal activity without restriction  { } **1** – Restricted in physically strenuous activity, but able to walk and do light work.  { } **2** – Able to walk and capable of all self-care, but unable to carry out any work. Up and about for  more than 50% of the waking hours.  { } **3** – Capable of only limited self-care, confined to a bed or chair more than 50% of waking hours  { } **4** – Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair. | | | | |
| **Section 7: Smoking Status** | | | | |
| { } Current { } Ex { } Never | | | | |
| **Section 8: Imaging** | | | | |
| All patients referred to the 2WW clinic must have had a Chest X-Ray or CT scan within the last 4 weeks  Date of X-Ray: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of CT scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If not performed at the RUH please attach copy of report. | | | | |
| **Section 9: CT Scans** | | | | |
| If patient has not had a CT scan, please request a **STAGING CT CHEST SCAN** when sending this referral.  Staging CT Chest scan requested: { } Yes { } Has had CT scan | | | | |
| **Section 10: Contact Details** | | | | |
| Queries about the Lung Cancer service at the RUH can be addressed by:  **Dr Masani**, Lead Clinician, Secretary: 01225 821841  **Lung Cancer Nurse Specialists**: 01225 821847 | | | | |
| **Section 11: Clinical Emergencies**  Please note that the two week wait referral form should not be used if you believe that your patient needs to be seen as an emergency, e.g. signs of superior vena cava obstruction, stridor. In this circumstance, please refer your patient as an emergency in the normal way. | | | | |
| **Section 12: For Hospital use only** | | | | |
| Date of 1st appointment: / / | | | Patient informed by: { } Letter { } Telephone | |