

## SUSPECTED UPPER GASTROINTESTINAL TRACT CANCER REFERRAL FORM

Please email to [ruh-tr.CancerReferrals@nhs.net](mailto:ruh-tr.CancerReferrals@nhs.net)

or

FAX within 24 hours to Cancer 2 Week Wait Office on **01225 821436**

REFERRER DETAILS	PATIENT DETAILS		
Name:	Forename:	Surname:	DOB:
Address:	Address:		Gender:
			Hospital No.:
			NHS No.:
Tel No:	Tel No. (1):	<i>Please check telephone numbers</i>	
	Tel No. (2):		
Email:	Carer requirements (has dementia or learning disabilities)?		Does the patient have the capacity to consent? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Decision to Refer Date:</b>	Translator Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Language:		Mobility:

**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. **For potentially limiting comorbid diagnosis**, please indicate severity: (e.g. 'ETOH excess, 50U / week' or "angina – precipitated by..."). Please include details of any physical findings as well as other important clinical information.*

Patient on anticoagulants (please specify which)

**Gall bladder cancer**

Ultrasound result indicates gall bladder cancer

**Liver cancer**

Ultrasound result indicates liver cancer

**Oesophageal and Stomach Cancer**

**These patients may be referred directly for an endoscopy. Please indicate if patient is NOT suitable for this procedure:** Yes  No

Upper abdominal mass consistent with stomach cancer

Dysphagia

Aged over 55 with weight loss **and** at least one of the following:

- Upper abdominal pain
- Reflux
- Dyspepsia

**Jaundice and suspected pancreatic cancer – please perform liver function test in parallel with the referral. Do not delay referral waiting for blood results or scans if not already performed**

Jaundiced patient

Non-jaundiced patient

CT indicates pancreatic cancer                      Date scan performed                      Location performed

Ultrasound indicates pancreatic cancer                      Date scan performed                      Location performed

If the patient has a mobile phone, please provide the number and advise the patient to bring their phone when they attend the hospital.

Mobile phone number:

The first appointment may be a test (USS, CT or MRCP). If this inappropriate please state the reasons:

**Further information on the pancreatic pathway can be found on the SWSCN website [here](#)**

**Please ensure that the following recent blood results are available (less than 8 weeks old):**

FBC, Hb, LFT, MCV, Ferritin, Iron studies, U&E, bilirubin. CA19-9, clotting

**Smoking status**

**WHO Performance Status:**

- 0** Fully active
- 1** Able to carry out light work
- 2** Up and 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 No

**Please confirm that the patient has received the two week wait referral leaflet:** Yes No

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:**

*For patients to be managed in a timely way for any eventual treatment, we aim to see them within 10 days of receiving this referral. Please ensure that the patient understands this expectation and the clinical importance of making themselves available for urgent assessment.*

**Please attach the additional clinical issues list from your practice system**

**Details to include:**

Current medication, significant issues, allergies, relevant family history, alcohol status and morbidities

**Trust Specific Details**

**For hospital to complete**

UBRN:

Received date: