**Suspected Breast Cancer Two Week Referral Form**

|  |  |
| --- | --- |
| **Referrer Details**  | **Patient Details**  |
| Name: | Name: | DoB: |
| Address: | Address: | Gender: |
| Hospital No.: |
| NHS No.: |
| Tel No: | Tel No. (1): | *Please check tel. nos.* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning difficulties)? | Capacity concerns? |
|  Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | Mobility: |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

|  |
| --- |
| **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 excluding or attach referral letter.* |

|  |  |
| --- | --- |
| ***Suspected Cancer Referral*** | ***Consider Symptomatic Breast Referral*** |
| [ ] Aged 30 and over and have an unexplained breast lump | [ ] aged under 30 with an unexplained breast lump with or without pain (consider)[ ]  Other (please detail in Clinical details section) |
| Aged 50 and over with any of the following symptoms in one nipple only:[ ] discharge[ ] retraction[ ] other changes of concern |
| ***Consider Suspected Cancer Referral*** |
| [ ] aged 30 and over with an unexplained lump in the axilla (consider) |
| [ ] haveskin changes that suggest breast cancer (consider) |
| **Please describe size and location of lump** |
| **Mammogram in last 3 years? Yes [ ]  No [ ]** Location: Date: **Re-Referral? Yes [ ]  No [ ]** Date Last Referred:  | [ ]  **Family history of breast cancer?** **Yes [ ]  No [ ]** If yes please specify:  |
| **Additional guidance** *nipple retraction – new onset and sustained**discharge - spontaneous clear of blood**Males Age 50 and over with unilateral firm sub areolar mass with or without nipple distortion and skin changes.* |

|  |  |
| --- | --- |
| **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 for 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 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:**Current medication, significant issues, allergies, relevant family history, alcohol status and morbidities |

|  |
| --- |
| **Trust Specific Details** |

|  |
| --- |
| ***For hospital to complete*** UBRN: Received date: |

# Please send via ERS