**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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| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

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| **FIT test prior to referral**As per cancer alliance and ICB endorsement,and in line with new national guidance to GPs**, *all patients should undertake a FIT test prior to referral on this pathway,*** unless presenting with **anal mass/ulceration** OR **abdominal/rectal mass** OR **Iron Deficiency Anaemia** (consider TTG/faecal calprotectin in younger patients and menorrhagia in menstruating patients prior to referral on this pathway).Please await the **result of the FIT test** **before** referring, unless agreed via Advice and Guidance with a Consultant viasft.salisburycolorectaladvice@nhs.net**FIT Value ……….** μg[ ]  Patient has a FIT value of ≥ 10 μg Hb/g faeces; positive FIT[ ]  Patient unable to undertake qFIT (pls complete Frailty below and outline reason in Clinical Details section)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. Please also consider repeating qFIT at 4-6 week (patients with two negative FIT test results have a colorectal cancer risk of <0.04%)  |

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| **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**[ ]  Unexplained weight loss and FIT ≥ 10[ ]  Unexplained abdominal pain and FIT ≥ 10[ ]  Change in bowel habit and FIT ≥ 10[ ]  Overt rectal bleeding and FIT ≥ 10 [ ]  Non-iron deficiency anaemia and FIT ≥ 10 [ ]  Iron Deficiency Anaemia [ ]  Palpable abdominal mass [ ]  Palpable rectal mass on PR |
| **Anal cancer** [ ]  Unexplained anal mass or unexplained anal ulceration |
| **Information required to book patient into the right type of appointment (*which is essential to allow the majority of patients to progress quicker via ‘straight to test’ and reduce patient harm*)*** Due to Frailty/Old Age/ Co-morbidity, the patient requires an OPA for assessment before diagnostics? [ ]
* Is the patient likely **fit** for bowel preparation/endoscopy and **willing** to undergo this type of procedure[ ]  Yes [ ]  No
* Please confirm that the following results are available:
	+ Ferritin, FBC, Hb - ***within last 8 weeks*** [ ]
	+ Renal function including eGFR - ***within the last 8 weeks*** [ ]
* Has the patient had previous bowel cancer or related surgery? [ ]  Yes [ ]  No
* Are you aware of the patient having an allergy to iodine/contrast medium (e.g. Gastrograffin, Primovist)? [ ]  Yes [ ]  No
* Is the patient diabetic? [ ]  Yes [ ]  No

Complete below *where not fully detailed/included* when form auto-populates re current medications:* 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

Do you consider it safe for the patient to stop all above medications for a period of up to 72 hours? [ ]  Yes [ ]  No If no, please provide further detail below |
| **Smoking status** | **Height/Weight/BMI if available** |
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| ***PLEASE TICK AS APPROPRIATE- THIS MUST BE COMPLETED AS IT IS ESSENTIAL TO ALLOW THE MAJORITY OF PATIENTS TO PROGRESS QUICKER VIA ‘STRAIGHT TO TEST’*** |
|  **[ ]** **[ ]** **[ ]  [ ]** **[ ]  [ ]** **[ ]** **[ ]** **[ ]**  |

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| 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* |

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| **Please attach additional clinical issues list from your practice system****Details to include:**Contraindications, current medication, significant issues, allergies, relevant family history, alcohol status and morbidities |

Please send **via ERS**