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| --- | --- | --- | --- |
| Please ensure that all patients referred using this proforma **have radiological evidence of metastatic disease and NO primary origin of this cancer.**  Metastases found on Liver USS **( If there is a solitary lesion, please refer using the Upper GI two week wait referral form):**  Scan date and location:  CT scan:  Scan date & location:  MRI:  Scan date & location:  Bone scan (Suspicious bone metastases with no obvious primary clinically and a normal PSA, and negative myeloma screen):  Scan date & location:  Other scan: | |  | **For information, please refer below to site specific MDT as indicated. If a patient has non-specific symptoms but suspicious for malignancy, please refer on the 2WW NSS pathway** |
| **Previous Diagnosis of Cancer**  Yes  No  Specify site and month/year of diagnosis: If yes, has this site been investigated for recurrence? Yes  No  Please attach as much information as possible about diagnosis, hospital involved and treatment received |
| **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% |
| **Alcohol status:** |
| **BMI** |
| **Clinical Details:** | | | |

**Cancer of Unknown Primary Two Week Wait Referral Form**

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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: YesNo Language: | | | | Mobility: | |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

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| --- |
| **Tumour markers (if available):**  CA125: CEA: AFP: CA15-3: CA19.9: |

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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 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:**  Past medical and surgical history:  Current medication:  Allergies:  Relevant family history: | | | | | |
|  | | | | | |
| **Blood Results (Last 2m):** | | | | | |
| **Hb** | **WBC** | **Neutrophil** | | **Platelets** | |
| **Sodium** | **Potassium** | **Creatinine** | | **Urea** | |
| **ALT** | **AST** | **Bilirubin** | **Albumin** | **ALP** | |
| **CRP** |  | | | | |
| **INR** |  | | | | |
| **Ca** | **Adjusted Ca** | **Phosphate** | | **Magnesium** | |
| **TFT** | **Glucose** | **Other tests** | | | |
|  | | | | | |
| **Trust Specific Details:** | | | | | |
|  | | | | |
| ***For hospital to complete*** UBRN:Received date: | | | | | |