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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 [x]  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**

|  |  |
| --- | --- |
| **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: |
| [ ]  | 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: |