Rapid assessment of patients with non-specific symptoms and clinical signs that could represent cancer or serious disease, but do not already have a designated pathway for urgent investigations or referral. Use Cancer Maps to support decision making if unsure.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient | | | | | | Referrer | |
| Title | <Patient Name> | Surname | <Patient Name> | | | GP Name (registered GP) | <Sender Name> |
| First Name | | <Patient Name> | | | | GP Name (referring GP) | <Sender Name> |
| Address | | <Patient Address> | | | | GP Telephone Number | <Sender Details> |
| Postcode | | <Patient Address> | | Date of Birth | <Date of birth> | GP Address | <Sender Address> |
| Gender | | <Gender> | | Age | <Patient Age> | GP fax number | <Sender Details> |
| Telephone (Home) | | <Patient Contact Details> | | | | Is an interpreter required? | Yes  No |
| Telephone (Mobile)  Patient consents to receive communication by mobile | | <Patient Contact Details>  Yes  No | | | | If so, which language? | <Main spoken language> |
| Telephone (Work) | | <Patient Contact Details> | | | |  | |
| NoK name / contact number | | <NoK Contact Details> | | | | If transport is required, GP must arrange transport for first visit. | |
| NHS Number | | <NHS number> | | | | Date of decision to Refer |  |
| E-mail address | | <Patient Contact Details> | | | | Date of Referral | <Today's date> |
| **Patient Access Information Requirements**: *<relating to physical ability, mental capacity or communication considerations>*   |  |  |  | | --- | --- | --- | | Able to carry out all normal activity (0) | Restricted in physically strenuous activity, but able to walk and do light work (1) | Able to walk and capable of all self care, but unable to carry out any work. Up and about more than 50% of waking hours (2) | | Capable of only limited self care, confined to bed or chare more than 50% of waking hours (3) | **Mental capacity *(Narrative if needed)*** | | |  | | | | | | | | |
| **Does the patient have any medical devices or implants?** Yes  No  If yes, please state what device <Device Details> | | | | | | | |
| ***Smoking Status***   |  |  |  | | --- | --- | --- | | Current smoker (1) | Ex-smoker (2) | Non-smoker - history unknown (3) | | Never smoked (4) | Not stated (PERSON asked but declined to provide response) (Z) |  | | | | | | | | |
| **Alcohol consumption**   |  |  |  | | --- | --- | --- | | Heavy (>14 units per week) (1) | Light (≤ 14 units per week) (2) | None ever (3) | | Not stated (PERSON asked but declined to provide response) (z) |  | |  |  | | | | | | | | |
| **Presenting Symptoms**   |  |  |  | | --- | --- | --- | | **Age 40+ AND**  **unexplained weight loss**  *(either documented >5% in three months or with strong clinical suspicion)* | Unexplained weight loss  Amount (kgs) {free text} Duration (weeks/months) {free text}  [o/e weight] - most recent reading  [o/e weight] - previous reading x 1 |  | | **Age 40+ AND**  **constitutional symptoms**  *(+4 weeks)* | Persistent and unexplained constitutional symptoms such as loss of appetite, fatigue, nausea and / or vomiting, malaise, bloating.  (Document in free text below) |  | | **Age 40+ AND**  **persistent pain**  *(+4 weeks)* | Persistent and unexplained pain such as vague abdominal pain, bone pain or progressive pain.  (Document in free text below) |  | | **Any age** | GP ‘gut feeling’  An intuitive opinion that there is something seriously wrong with your patient which might have cancer as a possible cause  (Document in free text below) | Duration (weeks/months)       / | | | | | | | | |
| **Symptoms on presentation *and reason for referral (Narrative)***  For ‘GP Gut instinct’ this field must be completed before form can be sent  **Date of first primary care presentation with non-specific symptoms**  **Number of primary care presentations relating to non-specific symptoms** | | | | | | | |
| **Primary Care pre-referral actions**   1. Please confirm the patient is aware of the possible diagnosis of cancer. Explain the urgency and importance of attendance to appointment due to the suspicion of cancer. 2. Please confirm the patient information leaflet has been given. 3. Please confirm the patient is available & willing to attend an appointment within the next 7 calendar days if required. 4. Please confirm that you have completed ALL the following filter function tests, which can be found on Order Comms/ICE by clicking on the ‘Clinical Page’ tab. Failure to do so may result in your referral being rejected and/or delay in your patient’s investigations  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | CXR | LFTS | Urine dipstick | FIT | FBC | ESR and/or CRP | | Location CXR done: | U&E with eGFR | Bone | LDH | Immunoglobulins | TSH | | HBA1c | PSA (Men) | CA-125 (Women) |  |  |  1. Please confirm that you have attached to this referral form a summary of past medical history and medications 2. Patients who receive a significant disease diagnosis including non-cancer will be internally referred within secondary care to the most appropriate service. All other patients will be referred / discharged back to primary care. | | | | | | | |

**PLEASE NOTE: IF YOUR PATIENT IS ELDERLY AND HAS MULTI-MORBIDITIES REQUIRING HOLISTIC REVIEW OR COMPREHENSIVE GERIATRIC ASSESSMENT PLEASE REFER TO ELDERLY MEDICINE OUTPATIENTS.**