**URGENT REFERRAL FORM FOR SUSPECTED UROLOGICAL CANCERS**

**\*INDICATES MANDATORY FIELDS – IF NOT COMPLETED OR NO TO ANY QUESTION REFERRALS MAY NOT BE ACCEPTED**

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| **PATIENT DETAILS** | | | | **GP DETAILS** | | | | |
| **Name:** |  | | | **Name:** | |  | | |
| **Address:** |  | | |  | |  | | |
|  |  | | |  | |  | | |
|  |  | | | **Phone No:** | |  | | |
| **NHS Number:** |  | | | **Fax No:** | |  | | |
| **Hospital number:** |  | | | **Name of referrer:** | |  | | |
| **Date of Birth:** |  | | | **Decision to refer date:** | |  | | |
| **Interpreter/Sign Language required:**  **Language:** | ☐ Yes ☐ No | | | **Date of referral if different from above:** | |  | | |
| **Contact No (next 48 hrs):** | **Home:** |  | **Work:** | |  | | **Mobile:** |  |
| **Patient consents to be contacted by text message?:** | | | | | | | Yes  No | |
| **GP Declaration – Please confirm and tick**  I have informed the patient they have symptoms which may be caused by cancer, that they are being referred urgently, and the nature of the tests likely to take place.  I have provided the patient with an Urgent Referral Patient Information Leaflet.  My patient has confirmed they are available to attend within 2 weeks.  My patient is aware that they will be offered the first available appointment at any one of our hospitals (Queen Elizabeth,  Heartlands, Solihull or Good Hope Hospital). | | | | | | | | |

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| **REASON FOR REFERRAL** | | | | | | | | |
| **Bladder/Renal** | Unexplained visible haematuria without UTI ≥45 years |  | | Visible haematuria persisting/ recurring after UTI treatment ≥45 years |  | Non-visible haematuria + dysuria or ↑WCC  ≥ 60 years  (If isolated Non-visible haematuria, please do a routine referral) | |  |
| **Testis** | (Swelling in body) Non-painful enlargement or change in shape or texture of the testis | | | |  | | | |
| **Renal** | Palpable renal mass | |  | | Solid mass in the kidney on imaging | |  | |
| **Penile** | Mass or ulcerated lesion, STI excluded/treated, unexplained or persistent symptoms affecting the foreskin or glans. | | | |  | | | |

FOR ALL PROSTATE REFERRALS PLEASE ENSURE ALL MANDATORY INFORMATION IS PROVIDED.

**\*INDICATES MANDATORY FIELD – IF NOT COMPLETED REFERRALS WILL NOT BE ACCEPTED.**

**This form is not for the referral of patients with a known prostate cancer diagnosis – please refer urgently to last known consultant**

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| **Prostate** | \*DRE: Please describe findings . | \* | \* PSA value(s):  ***(for a PSA value less than 10 please repeat after 6 weeks and refer if persistently raised)*** | \* |

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| **Age** | **Below 40**  **years** | **40-49 years** | **50-59 years** | **60 – 69 years** | **70-79 years** | **80+** |
| **PSA referral range** | **Use clinical judgement as per NICE guidelines** | **>2.5** | **>3.5** | **>4.5** | **>6.5** | **Patients with a healthy life expectancy of less than 10 years do not require urgent referral for mildly raised PSA (<20)** |

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| **For all patients**  \*Creatinine  \*EGFR  Results  (within last 3 months) |  | **\***Recentnegative  MSU *or* Negative urine dipstick required (within the last 4 weeks) | ***MSU / dipstick result:*** |

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| **Accessibility Needs:**  ☐ Wheelchair access  ☐ Deaf  ☐ Registered blind  ☐ Learning Disability  ☐ Other disability needing consideration  ☐ Accompanied by carer | **WHO Performance Status:**  ☐ 0 Fully active  ☐ 1 Able to carry out light work  ☐ 2 Up and about greater than 50% of waking time  ☐ 3 Confined to bed/chair for greater than 50%  ☐ 4 Confined to bed/chair 100% |
| **RISKS:**  ☐ Vulnerable Adult (detail below if any recording within last 3 years)  ☐ No Capacity to Consent  Any other known risk: | |

**Additional history/comments (including medications, allergies, major medical history or any recent investigations)**

**\*Please advise if patient is on anticoagulation**