GP REQUEST FORM –

Consultation Date ☐ Patient Details

Patient Consent ☐

Patient GP Surgery ☐

Pharmacist ☐

Name:-

Address :-

Telephone No :-

DOB:- Postcode:-

Dear Doctor,

I have seen your patient today and discussed the following

Change in bowel habits	☐	Abdominal pain	☐
Blood in stools	☐	Other (please specify)	☐
Unexplained weight loss	☐		

We are referring the patient to you in case their symptoms warrant further investigations.

Pharmacist Signature

For Surgery Team

Please hand this form to your CIM within you surgery.

Patient Consent

I have received an information sheet explaining why the pharmacist has referred me to my GP in case my symptoms warrant further investigations.

I agree for my details to be shared with my GP surgery for this purpose.

Patients Signature

Pharmacy stamp:

Please attach this to each Bowel Cancer Pharmacy Referral form

Patient Needed referral	Yes / No
Patient sent for 2 week wait referral	Yes / No
Patient required diagnostic tests	Yes / No
No action required	Yes / No

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Bowel Cancer – Early Intervention Pharmacy ACE programme

Dear Clinical Interface Manager (CIM) ,

Please complete the information below referring to all the Bowel Cancer referral forms received from community pharmacy.
Audit period 1-31st July 2015.
Please do not include any patient information.
If you have not received any forms please add Zero (0)

Practice Address

CIM Name
CIM Signature

	Total
Numbers of Bowel Cancer referrals from pharmacy	
Number of patients needing referral	
Number of patients sent for 2 week wait referral	
Number of patients that required diagnostic tests	
Number of patients with no action required	

Please email this form to Lynn McFarlane Cumbria.lpc@gmail.com

Or post to

Lynn McFarlane Cumbria LPC Unit 5E Lakeland Business Park Lamplugh Rd Cockermouth Cumbria CA13 7QT

We would like to thank you for collating this information.

Regards

Lynn McFarlane

Project Manager ACE Programme project A50/A66