Referral form

Patient details

First Name:
Surname:
Date of birth:
Address:

NHS number:

I confirm that I have a high index of suspicion for suspected malignancy of unknown origin based on the presence of one or more of the following (please tick those that apply)

	√
Unexplained weight loss of >5% body weight within 3 months give weight:	
Recurrent or progressive pain of unexplained aetiology >4 weeks give details:	
Severe constitutional symptoms e.g. fatigue, sweats of unexplained aetiology > 4 weeks give details:	
Palpable masses (give details):	
Other symptoms causing primary care team have a high index of suspicion Please state:	

I also confirm that the patient has no known contraindications to a contrast CT scan namely:

- Renal failure (eGFR <45, between 45- 60 require pre-contrast hydration)
- Allergy to contrast
- Risk of contrast enhanced nephropathy (e.g. severe dehydration)
- Morbid Obesity (> 220kg)
- Aged <18 years

Results of baseline FBC, U&E, LFT, TFT, Calcium, CRP, Urinalysis, Chest X-ray must be attached

Name of referrer:
Practice Address:

Email address:
Telephone no:

Complete next page CT CAP request then Email all pages to

DOB: NHS no:

REFERRAL DATE:

Please send the referral form by email.

Please X the corresponding box for the hospital the referral is being made to and send within 24 hours.

Hospital	Phone	Email: select & copy OR <Ctrl>+click
☐		Referral via Choose and Book
☐		

☐ **Patient has previously visited selected hospital** **HOSPITAL No:**

PATIENT DETAILS
SURNAME: **FIRST NAME:** **TITLE:**
GENDER: **DOB:** **NHS NO:**
ETHNICITY: **LANGUAGE:**
☐ **INTERPRETER REQUIRED** ☐ **TRANSPORT REQUIRED**
PATIENT ADDRESS: **POSTCODE:**
DAYTIME CONTACT☏:
HOME☏: **MOBILE☏:** **WORK☏:**
EMAIL:

GP DETAILS
USUAL GP NAME:
PRACTICE NAME: **PRACTICE CODE:**
PRACTICE ADDRESS:
BYPASS☏:
MAIN☏: **FAX:** **EMAIL:**
REFERRING CLINICIAN: **DIRECT TELEPHONE/MOBILE:**

CLINICAL DETAILS

REASON FOR REFERRAL

Note
SHOULD HAVE A SERIOUS POSSIBILITY OF CANCER
Do not need admission, and are too unwell to wait for 2 weeks for first appointment
Other explanation for their symptoms have been excluded or are very unlikely

☐ **Painless jaundice**
Bilirubin > 80 mmol/L, cause unknown

☐ **Unexplained and proven weight loss**
> 5% of documented weight loss
not previously investigated and no likely benign diagnosis

☐ **Vague abdominal symptoms**
Symptoms lasting 3 weeks, but under 6 months
No other likely cause
Not a chronic recurring problems
Unexpected presentation of patient

☐ **Second Emergency Department (A&E) presentation with abdominal pain**
Presented to A&E with abdominal pain on at least 2 occasions within 1 month
Not previously investigated; no other likely cause
Not a chronic recurring problems
Unexpected presentation of patient

HISTORY & PHYSICAL EXAMINATION

Relevant history or information:

Physical examination findings:

Any other relevant symptoms not covered by the guidelines:

Duration of symptoms:

Number of GP visits on these symptoms:

Number of A&E visits on these symptoms:

Family History of cancer including age at diagnosis:

☐ **I confirm that I have discussed the possibility with the patient that the diagnosis may be cancer**

☐ **I confirm that I have explained the appointment process to the patient, and the patient can be contact by phone.**
Note: If you are concerned the patient cannot be contacted by phone, please phone the MDC Pathway Coordinator to arrange an appointment for the patient before they leave the practice.

Please hand the patient a copy of the RAPID ACCESS MULTIDISCIPLINARY DIAGNOSTIC CENTRE PATIENT INFORMATION LEAFLET

DOB: NHS no:

FBC

TIBC

Ferritin

U&Es

LFTs

Blood Sugar

HbA1c

Bone Profile

Calcium

IMAGING STUDIES **Please include date:** **and location:**

PAST MEDICAL HISTORY

ALLERGIES

MEDICATION

Patient's details (or affix ID label)	*Patient Category*	~~NHS~~	~~PP~~	~~Cat II~~	GP	~~Other~~
Name						
Address						
.....						
Postcode ..... Tel						
DOB ..... Hosp.No.....						
NHS No						

Requestor

Signature.....

Print name.....

Designation.....

contact no:….....

Examination Requested:	**GP Stamp/details**
CT CAP with Contrast	
Relevant Clinical History:	**Email address for correspondence:**
What is the Clinical Question? ?occult malignancy	**Pregnancy rule** (Circle as appropriate) Any possibility of pregnancy? Yes / No LMP …… Signed ……..…..
MUO PATHWAY PILOT	**Priority** (Circle as appropriate) Routine Urgent Planned (date required)
Walking / Chair / Trolley / Bed / Mobile (Circle as appropriate)	**Transport Details** (Circle as appropriate) Ambulance Yes/No Escort Yes/No

Information required for booking (Circle as appropriate)

Asthma	Yes/No	**Does this patient have any special requirements?** eg DDA, hoist
eGFR less than 60 please enter results here_____	Yes/No	
Diabetic	Yes/No	
On metformin	Yes/No	
Recent MI	Yes/No	
MRSA	Yes/No	**Comments:**
Hep B	Yes/No	
HIV	Yes/No	

PLEASE ATTACH RELEVANT BLOOD RESULTS