NOTE: This form is NOT for patients aged <16 years

East and North Hertfordshire NHS Trust

LUNG SUSPECTED CANCER REFERRAL FORM

Date of GP decision to refer: Click here to enter a date. No. of pages sent:

EMAIL REFERRAL TO: twowwgpreferrals.enh-tr@nhs.net

PATIENT DETAILS –Must provide current telephone number.

Last name: First name:

Gender: M ☐ F ☐ DOB:

NHS No:

Address:

Tel (mobile/daytime):

Tel (evening):

Patient agrees to telephone message being left? Y ☐ N ☐

Email:

Interpreter required? Y ☐ Language/Hearing:

Learning difficulties? Y ☐

Mental capacity assessment required? Y ☐

Known safeguarding concerns? Y ☐

Mobility requirements (unable climb on/off bed)? Y ☐

REFERRAL CRITERIA

☒ **Unexplained haemoptysis**

Order URGENT CXR at time of referral but do not wait for result before submitting referral.

☒ **Abnormal CXR suggestive of lung cancer/ mesothelioma**

For all other symptoms (see below) it is mandatory to order & review CXR before referral.

****please order an URGENT CT SCAN at ENHT at time of referral ****
(to be performed within 2 weeks)

PLEASE CONFIRM THAT YOU HAVE ORDERED AN URGENT CT SCAN ☒

SYMPTOMS & CLINICAL EXAMINATIONS (usually ≥40 yrs)

Stridor or Superior Vena Cava Obstruction: medical emergency

☐	Persistent or recurrent chest infection
☐	Chest signs consistent with lung cancer
☐	Chest signs of pleural disease [2015]
☐	Finger clubbing
☐	Persistent cervical lymphadenopathy
☐	Supraclavicular lymphadenopathy
☐	Thrombocytosis [2015]
☐	2 of the following; OR
☐	1 if EVER: ☐ smoked OR ☐ exposed to asbestos: ☐ Cough ☐ Fatigue ☐ Shortness of breath ☐ Dysphasia ☐ Wheeze ☐ Chest/shoulder pain ☐ Hoarseness ☐ Unexplained loss of appetite [2015] ☐ Unexplained weight loss
☐	Other primary cancer (specify):

GP DETAILS

GP name:

Practice Code:

Address:

TEL:

FAX:

Practice email:

Your Practice's direct access tel/GP mob - for use by Consultants only:

INVESTIGATIONS REQUIRED TO SUPPORT REFERRAL

Most patients will go straight to diagnostic test. The following tests are essential:

☐ FBC	☐ LFT	☐ U+E
☐ Clotting	☐ Glucose	☐ CRP
☐ EGFR	☐ Creatinine	☐ Bone profile

PATIENT MEDICAL HISTORY

Existing conditions & risk factors (*inc. smoking status*):

☐ patient is currently a smoker

☒ patient referred to stop-smoking advisor

Current medication (attach list & indications)*:*

Allergies Y ☐

Anticoagulants/Antiplatelets Y ☐

Immunosuppressants Y ☐

Diabetic Y ☐

WHO Patient Performance status (see key below)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

ADDITIONAL INFORMATION

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL

Cancer needs to be excluded	☐
Patient given referral information leaflet	☐
Date(s) unavailable next 14 days:	

PLEASE ATTACH A PATIENT SUMMARY INCLUDING: REFERRAL LETTER, INVESTIGATION RESULTS, PMH, UP-TO DATE MEDICATIONS LIST AND INDICATIONS

If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.

If you have not received acknowledgement within 48 hours (Mon-Fri) contact 2ww supervisor on 01438 285206

WHO PATIENT PERFORMANCE STATUS KEY

0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out light/sedentary work, e.g. house/ office work.
2	Ambulatory and capable of self-care, but unable to carry out work activities. Up and active > 50% of waking hours.
3	Capable of only limited self-care. Confined to bed or chair >50% of waking hours.
4	Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair.

FOR HOSPITAL USE ONLY

Date referral received:	_ _/_ _/_ _ _ _	If 1st appointment date not accepted, give reason/s:
1st appointment date offered:	_ _/_ _/_ _ _ _	
2nd appointment date offered:	_ _/_ _/_ _ _ _	