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

East and North Hertfordshire NHS
NHS Trust

OESOPHAGO-GASTROINTESTINAL 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 – <u>Must</u> provide current telephone no	**GP DETAILS**
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 ☐	GP name: Practice Code: Address: TEL: FAX: Practice email: Practice's direct access telephone/GP mobile – for use by Consultant only:
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 ☐	**DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL** Cancer needs to be excluded ☐ Patient given referral information leaflet ☐ Is patient willing & able to undergo endoscopic diagnostic tests? ☐ Date(s) unavailable in next 14 days: **WHO Patient Performance status: see key below (<u>MANDATORY</u>)** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

CRITERIA FOR URGENT SUSPECTED CANCER REFERRAL

☐	Age ≥55 with dysphagia **NB if <55 with dysphagia please contact consultant gastroenterologist to discuss before referral** **OR**
☐	Age ≥55 with weight loss and any of the following: ☐ Upper abdominal pain ☐ Reflux ☐ Dyspepsia
☐	Upper abdominal mass consistent with stomach cancer **[2015]**

SYMPTOMS

☐	Reflux	☐	Dyspepsia	☐	Vomiting	☐	Nausea
☐	Back pain	☐	Haematemesis	☐	Weight Loss	☐	Upper Abdominal Pain
☐	Iron Deficient Anaemia (please confirm with Serum Ferritin) **HB:**						

COMORBIDITY

☐	Significant Cardiac Disease	☐	Diabetes	☐	Allergies
☐	Significant Respiratory Disease	☐	Warfarin or other Anticoagulants/Antiplatelets	☐	Patient is **NOT** fit for endoscopy
☐	Significant Neurological Disease	☐	Aspirin / NSAID	☐	
☐	Significant Liver Disease	☐	Immunosuppressants	☐	

ADDITIONAL INFORMATION/RISK FACTORS

☐	Previous Gastric Surgery	☐	Barrett's Oesophagus	☐	Known Dysplasia
☐	Atrophic Gastritis	☐	Pernicious Anaemia	☐	Family History of Gastric Cancer
☐	Suspicious imaging (please attach report)				

ADDITIONAL INFORMATION

CURRENT MEDICATION & SMOKING STATUS

☐ Patient is currently a smoker ☐ Patient referred to stop-smoking service

PLEASE ATTACH A PATIENT SUMMARY INCLUDING: REFERRAL LETTER, INVESTIGATION RESULTS, PMH, CURRENT MEDICATIONS AND INDICATIONS

If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant a referral for suspected cancer, please either phone the Consultant Gastroenterologist or disclose full details in your referral letter and provide a contact number where a Consultant Gastroenterologist can reach you promptly.

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

WHO PATIENT PERFORMANCE 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:	_ _/_ _/_ _ _ _	