NHS
Mount Vernon
Cancer Network

URGENT TWO WEEK REFERRAL. SUSPECTED LOWER GI CANCER

This form to be used only if the patient fulfils the following criteria.

PATIENT DETAILS	GP DETAILS
Surname	Name
Forename (s)	Practice Code
DOB Age	Telephone
NHS Number	Fax
UBRN	
Address	Practice name/address
Postcode	
Telephone ☐ Home	Postcode
☐ Work	Translator required ☐
☐ Mobile	Specify language

Confirm that the patient has been given a 2-week wait referral information leaflet. ☐

Confirm that the patient understands this is a referral to rule out suspected cancer. ☐

Confirm that the patient is willing and able to attend in the next 2 weeks. ☐

☐ DEFINITE PALPABLE Rt. SIDED ABDOMINAL MASS (probably involving large bowel) **YES/NO**

☐ DEFINITE PALPABLE MASS ON RECTAL EXAMINATION **YES/NO**

☐ UNEXPLAINED Fe ↓ ANAEMIA in men (<11g) and in non menstruating women (< 10g)
(Iron deficiency **MUST** be confirmed with serum ferritin) Hb _____ Ferritin _____

☐ **TTGAB confirm requested or results attached**
NB: Constipation alone not sufficient for 2WW referral

☐ PERSISTENT (>6 wks) RECTAL BLEEDING/CHANGE IN BOWEL HABIT –
(to looser stools and/or ↑ frequency) Duration _____

Either ☐ **40 – 60 yrs** old with rectal bleeding **and** change of bowel habit

Or ☐ **60 yrs** or **over** with rectal bleeding independent of change in bowel habit and in absence of anal symptoms

Or ☐ **60 yrs** or **over** with change in bowel habit independent of rectal Bleeding

Additional information / other reasons for requesting urgent referral.

☐ other primary cancer, specify site.

Please attach printout of PMH, drugs and referral letter.

FAX East & North Herts NHS Trust: 01438 781835 ☐

If you have not received acknowledgement with 48hrs (Mon-Fri) please telephone 2/52 Wait Supervisor on **01438 285206.**

FAX West Herts Hospitals Trust: 01727 897199 ☐

FAX Luton & Dunstable NHS Foundation Trust: 01582 497910 or 497911 ☐

FOR HOSPITAL USE ONLY

Date referral received:
1st appt date: If 1st appt not accepted give reason/s:
2nd appt date