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| **UROLOGY SUSPECTED CANCER REFERRAL FORM**  Date of GP decision to refer: <Today's date> No. of pages sent: | |
| **NOTE: This form is NOT for use for patients under 16** | |
| **INFORMATION PROVIDED TO PATIENT (To be provided by referring Clinician) please tick** | |
| Patient has been informed that cancer needs to be excluded |  |
| Patient has been given written information leaflet regarding the 2 week wait pathway |  |
| Patient has confirmed they are available for the next 14 days |  |

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| **PATIENT DETAILS** – **Must provide current telephone number** | | | | | | |
| Last name: | <Patient Name> | | First name: | | <Patient Name> | |
| Gender: | <Gender> | | DOB: | | <Date of Birth> | |
| NHS No: | <NHS number> | | Ethnicity: | | <Ethnicity> | |
| Address: | <Patient Address> | | | | | |
| Tele (Day/Work): | <Patient Contact Details> | | Tele (Evening/Home): <Patient Contact Details> | | | |
| Mobile No: | <Patient Contact Details> | | Patient happy for a message to be left | | |  |
| Email: | <Patient Contact Details> | | | | | |
| **GP DETAILS** | | | | | | |
| GP name: | <Sender Name> | | | Practice Code: <Organisation Details> | | |
| Practice Address: | <Sender Details>, <Sender Address> | | | | | |
| Telephone: | <Sender Details> | Practice email: <Organisation Details> | | | | |
| Bypass no.: |  | | | | | |

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| **WHO PERFORMANCE STATUS** | | Select one |
| 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 or office work. |  |
| 2 | Ambulatory and capable of self-care, but unable to carry out work activities.  Up and active more than 50% of waking hours. |  |
| 3 | Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours. |  |
| 4 | Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair. |  |

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| **ADDITIONAL CONSIDERATIONS** | | |
| Transport required? |  | **If yes, please give details:**    <Diagnoses> <Diagnoses> <Diagnoses> <Diagnoses>  <Diagnoses> |
| Speech/Language/Hearing difficulties? |  |
| Carers details |  |
| Learning difficulties? Cognitive or sensory impairment? |  |
| Safeguarding concerns? |  |
| Mobility impairment? (unable to climb on/off bed)? |  |

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| **BACKGROUND INFORMATION/RISK FACTORS** | | | |
| BMI | <Numerics> | Smoker/ex-smoker | <Diagnoses>, <Numerics> |
| Alcohol | <Diagnoses>, <Numerics> | Allergies | <Allergies & Sensitivities> |
| Relevant family history |  | | |

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| **Prostate cancer** | |
| Abnormal digital rectal examination |  |
| All patients with PSA of 10 ng/ml or more |  |
| NB: Patients with raised PSA and benign digital rectal examination it is necessary to exclude UTI as a possible cause as up to 15% of such patients will have a UTI to account for their elevated result. If infection is confirmed, treat appropriately and **REPEAT** the PSA 6 weeks later.  NB: Asymptomatic patients with single raised PSA ≤10 ng/ml **REPEAT** PSA in 4 weeks before 2WW referral is made. This is to exclude physiological or short term illness which may cause an isolated PSA rise.  NB: PSA is **not** recommended in men <40 years unless prostate cancer is clinically suspected. | |
| **PSA age specific ranges.**  **Patient requires referral if:**  40-49 years: ≥2.5 ng/ml |  |
| 50-69 years: ≥3.0 ng/ml |  |
| 70-75 years: ≥4.0 ng.ml |  |
| 76-79 years: ≥5.0 ng/ml |  |
| ≥80 years: ≥10 ng/ml |  |

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| **Bladder/Renal cancer** | | **Tick if applies** |
| Aged 45 and over and have unexplained visible haematuria without urinary tract infection | |  |
| Aged 45 and over and have visible haematuria that persists or recurs after successful treatment of urinary tract infection | |  |
| ‘Bladder/renal mass suspected’ on scan  Date of scan: | |  |
| **Bladder only**: Aged 60 and over and have unexplained microscopic haematuria and either dysuria or a raised white cell count: | Dysuria |  |
| Raised white cell count |  |
| **NB: Consider non-urgent referral in patients aged** ≥**60 years with unexplained recurrent or persistent UTI.** | | |

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| **Testicular cancer** | **Tick if applies** |
| Non-painful enlargement or change in shape or texture |  |
| Abnormal ultrasound scan, please attach report with this referral |  |

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| **Penile cancer** | **Tick if applies** |
| A penile mass or ulcerated lesion, where an STI has been excluded or already treated |  |
| A persistent penile lesion after treatment for sexually transmitted infection has been completed |  |
| Unexplained or persistent symptoms affecting the foreskin or glans |  |

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| **ADDITIONAL INFORMATION**    <Event Details> | | |
| **MEDICAL PROBLEMS**    <Problems>  <Summary> | | |
| **Mandatory tests** | **Date** | **Result** |
| **PSA (first):** | <Numerics> | <Numerics> |
| **PSA (second):** |
| **U&E/eGFR** | See below | See below |
| **Ultrasound scan – Send request but DO NOT WAIT FOR RESULT TO SEND REFERRAL** |  | (If known) |

**Radiology:** (In last 6 months)

<Arden's Ltd - Investigations: Radiology last 6m (view)>

**Blood Results** (Last 2m):

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| **FBC** | <Numerics> | Hb <Numerics>, WCC <Numerics>, Plts <Numerics>, MCV <Numerics>, Neut <Numerics> | | |
| **UE** | <Numerics> | Na <Numerics>, K <Numerics>, Urea <Numerics>, Creat <Numerics>, eGFR <Numerics> | | |
| **LFT** | <Numerics> | ALT <Numerics>, Alk Phos <Numerics>, Bili <Numerics>, Alb <Numerics>, GGT <Numerics>, Serum globulin <Numerics>, Total Protein <Numerics> | | |
| **CRP** | <Numerics> | <Numerics> | **ESR** | <Numerics> |
| **TFTs** | <Numerics> | TSH <Numerics>, Free T4 <Numerics> | **INR** | <Numerics> |
| **Bone** | <Numerics> | Ca <Numerics>, Ca cor <Numerics>, Ca adj <Numerics>, Phos <Numerics> | | |
| **Iron** | <Numerics> | Ferritin <Numerics>, Iron Saturation <Numerics>, TIBC <Numerics> | | |
| **Vitamins** | <Numerics> | B12 <Numerics>, Folate <Numerics> | | |
| **Lipids** | <Numerics> | Chol <Numerics>, LDL <Numerics>, HDL <Numerics>,Chol:HDL ratio <Numerics>, Tri <Numerics> | | |
| **Random Glucose** | | <Numerics> | **Fasting Chol.** | <Numerics> |
| **Fasting Glucose** | | <Numerics> | **HbA1c** | <Numerics> |

**FOR HOSPITAL USE ONLY**

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