Suspected Colorectal Cancer – Referral Form for Telephone Assessment and Straight-To-Test Pathway

This form should be submitted via the Referral Support Service

Reference/Priority

Referral Date:	Priority:	NHS Number:
Referral Date	2WW	NHS Number

Patient Details

Title:	Forename(s):	Surname:
Title	Given Name	Surname
Date of Birth:	**Gender:**	**Ethnicity:**
Date of Birth	Gender	Ethnic Origin

Contact Details

Address Line 1:	Address Line 2	Address Line 3:
Home Address House Name/Flat Number	Home Address Number and Street	Home Address Village
Town:	**County:**	**Postcode:**
Home Address Town	Home Address County	Home Address Postcode
Phone:	**Mobile:**	**Text Message Consent:**
Patient Home Telephone	Patient Mobile Telephone	No
Email:		
Patient E-mail Address		

Referrer/Practice Details

Referring Name:	Referrer Code:	Practice Code:
Referring User	Free Text Prompt	Organisation National Practice Code

Clinic Details

Specialty:	Clinic Type:	Named Clinician:
2WW	2WW Lower GI	

Patient Choice Preferences

Provider 1:	Provider 2:
Referral Target Service Name	

Preferences

Vulnerable Patient:	Vulnerable Reason:	Confidential/Silent Referral:
No		No
Preferred Contact Time:	**Interpreter Required:**	**Preferred Language:**
	No	Main Language

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Referral Details

Non-clinical information for the booking team:

Provisional Diagnosis:
Referral Reason

Smoking Status:
137811000006103

Referral Reason/Letter Text

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Patient Awareness

Confirm the patient understands that they have been referred onto a "suspected cancer pathway" and may need invasive investigations:	Please select below
Confirm that your patient has received the information leaflet	Please select below
Confirm the patient is a suitable candidate for telephone assessment	Please select below
Confirm the patient has been informed that they may be straight to test which is an invasive test	Please select below
Confirm the patient is aware they may not be seen by a clinician	Please select below
Confirm the patient is available to attend an appointment or an investigation within 2 weeks of this referral and if necessary subsequent appointments over the next few weeks**	Please select below

Reason for Referral

NICE recommended **refer fast track** if

- Age ≥ 40 unexplained weight loss *and* abdominal pain ☐
- Age ≥ 50 unexplained **rectal bleeding** ☐
- Age ≥ 60 **persistent change in bowel habit** (looser stool, increased frequency or constipation) ☐
- Age ≥ 60 iron deficiency anaemia (confirmed by haemoglobin and ferritin levels) ☐
- Tests show occult blood in their faeces as part of low risk assessment ☐

NICE recommend **consider fast track** referral if

- Any age **abdominal mass or rectal mass** ☐
  (refer pelvic mass to gynae and upper abdominal mass use upper GI fast track form)
  Attach scan report if already performed
- Age ≤ 50 with **unexplained rectal bleeding and** ☐
  - **abdominal pain** ☐
  - **change in bowel habit** (looser stool, Increased frequency or constipation) ☐
  - **weight loss** ☐
  - **iron deficiency anaemia** (confirmed by haemoglobin and ferritin levels) ☐
- Any age unexplained anal mass and/or anal ulceration ☐

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History

Please enclose as much information as possible about the presentation and the patient's performance status

PLEASE ENSURE A FIT TEST IS REQUESTED WITH ALL REFERRALS EXCEPT ANAL MASS AND/OR ANAL ULCERATION

PLEASE ENSURE BLOODS FOR FBC, U&E's, CRP AND FERRITIN ARE ALSO REQUESTED IF NOT ALREADY DONE SO

Risk of Cancer

GPs VIEW OF RISK OF CANCER WHERE 1 IS LOW RISK AND 10 IS HIGH RISK — Please select below

Abdominal Examinations

Normal Findings ☐

If abnormal findings, please document any masses felt during examination:

Digital Per Rectum Examination

Normal Findings ☐

If abnormal findings, please document any masses felt during examination:

WHO Performance status (helps to decide fitness for specific tests)

0 = Fully active, able to carry out all pre-disease performance without restriction ☐

1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g. light house work, office work ☐

2 = Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about 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). ☐

Referral Checklist - ***THIS MUST BE COMPLETED PRIOR TO REFERRING THE PATIENT***

Referral Letter (see page 2) ☐

Abdominal and DPR examination performed ☐

Performance status ☐

Past Medical History ☐

Current Medications ☐

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Allergies/Sensitivities	☐
Blood tests	☐
FIT test requested (except anal mass)	☐
Weight	☐
Patient's contact telephone number	☐

Blood Results

Hb: 1022431000000105
MCV: 1022491000000106
Ferritin: 993381000000106
Creatinine: 1000731000000107
eGFR: 1020291000000106
CRP: 1001371000000100
TSH: 1022791000000101
Coeliac Serology: 1013671000000106
HbA1c: 999791000000106

Active Problems

Family History: 57177007
Problems
Values and Investigations
Allergies
Alcohol Consumption
Smoking
Weight
Height
BMI
Blood Pressure

Medication

Medication

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YORK TEACHING HOSPITAL NHS TRUST
Primary Care CT Scan Referral

Incomplete requests could delay this examination or result in an incomplete investigation

Patient Information
Patient Name: Full Name
NHS Number: NHS Number
DOB: Date of Birth
Gender: Gender
Address: Home Full Address (single line)
Telephone Number: Patient Home Telephone
Mobile Number: Patient Mobile Telephone

Examination requested (see CCG guidelines):
Use drop down list or freetext below
Freetext:

Patient is on a fast track pathway ☐ Yes

Clinical details and diagnosis:

From April 2018 all patients needing IV contrast for CT need to have a Creatinine and eGFR no more than 3 months prior to their scan.

Please either provide the results below and date of test
*Serum Creatinine: **1000731000000107**
*eGFR: **1020291000000106**

OR: Order bloods and tick the box ☐
Requests may not be processed until results are available to us

Consider renal prophylaxis, if creatinine > 150 µMol AND eGFR < 45 ml /min / m^2

Examinations not requiring IV contrast are
- CT KUB
- CT sinuses
- CT head (unless looking for metastases)
- HRCT of the chest
- Orthopaedic CT

Diabetic? 44054006 / 46635009
Is the patient on Metformin?
Yes ☐ No ☐
If diabetic and on metformin, please ensure creatinine & eGFR (<3 months old) are provided.

☐ This request been discussed with a consultant?
Who?
☐ This test is part of a CCG approved pathway
Which one?
☐ This test has been suggested by a specialist team
Who?

Possible pregnancy?
Select from drop down list

Disability? Yes ☐
Hearing ☐ Visual ☐ Learning ☐

Please describe mobility:
Walking ☐ Trolley ☐ Chair ☐
Bed ☐ Hoist ☐ O_2 ☐

Weight

Referring Clinician Requests only accepted from Trust approved referrers - Ionising Radiation (Medical Exposure) Regulations 2000
GP Practice:
GMC Registration Number / NMC short code: (compulsory for email requests)
Date of referral:

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Patient ID Label Here

CT appointments: York: (01904) 725936 ext. 5936 Scarborough: (01723) 342044 ext 2044

For Radiology Use Only **U**rgent ☐ **S**oon ☐ **R**outine ☐

Authorised by: Practitioner: Operator:
Scan type:
Comments:

IV Contrast: **Y** ☐ **N** ☐ Oral Contrast: **Y** ☐ **N** ☐

Oral Prep Volume: 500ml / 1000mls / 800mls
- Omnipaque 350 ☐
- Gastrografin ☐
- Water ☐
- Klean Prep ☐
- EZ CAT ☐

For Radiology Use Only

ID check
Name ☐ DoB ☐ Address ☐ Wristband ☐
ID checked by - Name of Staff:

Operator: Room: Dose: mAs* mGy.cm²*

(Please circle as appropriate)*

Pregnancy Status
There is no possibility that I am pregnant (signature): Date:
1st day of LMP: THE 10/28 DAY RULE APPLIES
Checked by (staff): Date:
Decision to over-rule (Dr): Reason:

Oral contrast check	**IV contrast and buscopan check**
Name ☐ DoB ☐ allergies ☐ omnipaque ☐ kleanprep ☐ ezcat ☐ water ☐ gastrografin ☐ Vol given by: 500 / 1000 / 800mls	allergies* ☐ asthma ☐ diabetic ☐ metformin ☐ hyperthyroidism ☐ buscopan ☐ mys gravis ☐ heart / bp ☐ glaucoma ☐ bladder outflow ☐ obstruction ☐ Agent: lot no: Given by:

*Comments (including details of patient allergies):

Radiology appointment date & time: