South Yorkshire and Bassetlaw Integrated Care System
CANCER ALLIANCE
Working with Derbyshire

Upper GI

Fast Track Referral – 2 Week Wait

Please refer via the e-Referral Service

Patient Details:

Patient Name			
Address			
DOB		**NHS No.**	
Home Tel. No.		**Gender**	
Mobile Tel. No.		**Ethnicity**	
Preferred Tel. No		**Email Address**	
Main Spoken Language		**Interpreter needed?**	☐ Yes ☐ No
Ambulance booking required?	☐ Yes ☐ No	**Patient agrees to telephone message being left?**	☐ Yes ☐ No
Communication requirements:	Hard of hearing: ☐ Visually impaired: ☐ Learning/mental difficulties: ☐		

Registered GP Details:

Practice Name			
Registered GP		**Usual GP**	
Registered GP Address			
Tel No.		**Fax No.**	
Email		**Practice Code**	

Please use separate children's proforma for patients under 16

Dear Colleague,

I would be grateful for your opinion on the patient named above who presents with clinical findings I consider suspicious of malignancy.

1. I can confirm that I have discussed the possibility with the patient that the diagnosis may be cancer **Yes** ☐ **No** ☐

2. I confirm that I have explained the 2 week wait appointment and the patient has confirmed that they can be available to attend an appointment within the next two weeks **Yes** ☐ **No** ☐

3. I can confirm that the patient is fit for 'straight to test' endoscopy and that the patient has been informed that they may be contacted by phone and that a test may be offered anywhere within the network in order to facilitate timely investigations **Yes** ☐ **No** ☐

PLEASE HAND THE PATIENT A COPY OF THE URGENT REFERRALS PATIENT INFORMATION LEAFLET

WHO performance status: (please tick for ALL patients)	
0 – Able to carry out all normal activity without restriction	☐
1 – Restricted in physically strenuous activity but able to walk and do light work	☐
2 – Able to walk, capable of all self-care. Unable to carry out any work. Up & about 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.	☐

Guidelines for Suspected Upper GI Cancer Referral	
Ensure your patient is fit and willing to have endoscopy and understands this is a direct referral.	☐
Check FBC for anaemia and U&E to facilitate quick referral for CT scan. Note: H.pylori testing should not affect the decision to refer for suspected cancer	☐
Have a lower threshold for non-urgent UGI endoscopy in patients > 55 years with suggestive symptoms, particularly weight loss	
For symptoms not matching the criteria on this form, please follow the link to NICE cancer guidelines www.nice.org	

Oesophageal or Gastric Cancer:	Tick if criteria applies
Dysphagia	☐
Aged ≥55y with weight loss with any of; • Upper abdominal pain • Reflux/ Dyspepsia	 ☐ ☐

Pancreatic, Liver or Gallbladder Cancer:	Tick if criteria applies
Aged 40 and over **with** jaundice	☐

If patient > 60 years with weight loss **(<u>in the absence of jaundice</u>)** and if any of the following apply, refer for urgent CT scan or ultrasound if CT not available:

- Abdominal mass
- New onset diabetes
- Diarrhoea
- Back pain
- Abdominal pain
- Nausea/vomiting
- Constipation

<u>Clinical Information</u>

Clinical history and examination findings

Current medication

Antiplatelet therapy? **Yes** ☐ **No** ☐ **If yes, please specify:**

Anticoagulants? **Yes** ☐ **No** ☐ **If yes, please specify:**

Allergies

Results of any investigations already undertaken:

Awaiting the results of these investigations **<u>should not delay referral</u>**, especially if high clinical suspicion of malignancy

FBC
INR
U&E
LFT
Ultrasound scan