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| Text  Description automatically generated | | **UPPER GI**  ***Urgent Suspected Cancer (USC) referral***  ***Please refer via e-Referral Service*** | |
| **Please use separate children’s proforma for patients under 16.** | |

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| **Patient details** | | | |
| **Patient Name** | ${firstname} ${surname} | | |
| **Address** | ${patientAddress}  ${postcode} | | |
| **DOB** | ${dob} | **NHS No.** | ${nhsNumber} |
| **Home Tel. No.** | ${home} | **Gender** | ${gender} |
| **Mobile Tel. No.** | ${mobile} | **Ethnicity** | ${ethnicity} |
| **Preferred Tel. No.** | ${preferredNumber} | **Email Address** | ${email} |
| **Main Spoken Language** | ${language} | **Interpreter needed?** | Yes  No |
| **Transport needed?** | ${transportNeeded} | **Patient agrees to telephone message being left?** | Yes  No |
| **Communication requirements** | Hard of hearing:  Visually impaired:  Learning/mental difficulties:  Dementia:  Has the patient capacity? Yes  No  Communication difficulties other: (please specify)  ${communicationDifficultiesOther} | | |
| **Safeguarding concerns?** | ${safeguardingConcerns} | | |
| **Date of Decision to Refer** | ${createdDate} | | |

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| **Registered GP details** | | | |
| **Practice Name** | ${practiceName} | | |
| **Registered GP** | ${usualName} | **Usual GP / Referring GP** | ${referringClinical} |
| **Registered GP**  **Address** | ${practiceAddress} | | |
| **Tel No.** | ${main} | **Fax No.** | ${fax} |
| **Email** | ${gpEmail} | **Practice Code** | ${practiceCode} |

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| **Patient engagement** | |
| **The patient has been informed that the reason for referral is to rule out or rule in Cancer.** |  |
| **Supporting information (USC leaflet) provided** |  |
| **The patient has been informed of the likely next pathway steps and the time in which they should be contacted?** |  |
| **The patient has confirmed that they are willing and available to be contacted and attend the hospital for appointments and tests within the required timeframes?**  **(and that this may include virtual or telephone consultations if appropriate)** |  |
| **Does the patient want a relative present at the appointment** | Yes  No |
| **Patient or Carer Concerns/ Support Needs at the point of referral:** | |
| ${carerConcernsOrSupportNeeds} | |
| **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 |

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| **Guidance for 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 |  |
| Consider non-urgent UGI endoscopy for patients with:   * Haematemesis * Aged ≥ 55y with:   + Treatment resistant dyspepsia   + Upper abdominal pain with anaemia   + Thrombocytosis with: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain   + Nausea or vomiting with: weight loss, reflux, dyspepsia, upper abdominal pain. | |
| For symptoms not matching the criteria on this form, please follow the link to NICE cancer guidelines [www.nice.org](http://www.nice.org) | |

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| **Referral criteria** | | |
| **Oesophageal or gastric cancer** | Dysphagia |  |
| Aged ≥55y with weight loss with any of:   * Upper abdominal pain * Reflux/ Dyspepsia |  |
| Mass consistent with stomach cancer |  |
| **Pancreatic, liver or gall bladder cancer** | Aged 40 and over **with** jaundice |  |
| **If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.** | |  |

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| **CT abdomen** |
| If patient ≥ 60 years with weight loss (**in the absence of jaundice**) 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 |

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| **Please add clinical details and examination findings**  **(this can be copied from your consultation note)** |
| ${symptomsAndExaminationFindings} |

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| **Anticoagulation status** | | |
| **Is the patient currently on any anticoagulants?** | Yes  No | ${anticoagulantsTextarea} |
| **Is the patient currently on any antiplatelet medications?** | Yes  No | ${antiplateletsTextarea} |

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| **Relevant investigations** | |
| **All patients requiring a 'suspicious of cancer' referral must have a recent (< 3 months) FBC, Ferritin and U&E result to facilitate efficient pathway next steps.** | |
| **FBC** | ${fbcG} |
| **U&E** | ${renalFunctionG} |
| **Ferritin** | ${ferritin} |
| **LFTs** | ${lftGroup} |
| **INR** | ${clottingG} |
| **Ultrasound scan** | ${abdominalUltrasoundG} |
| **Other** | ${relevantInvestigations} |

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| **Performance status - WHO classification** | |
| **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 and capable of all self-care, but unable to carry out any work. 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 on any self-care. Totally confined to bed or chair** |  |

**Consultations**

${additionalClinicalInfo}

**Past Medical History**

${medicalHistory}

**Family history**

${relevantFamilyHistoryOfCancer}

**Current Medications**

${medication}

**Allergies**

${allergies}

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| **To be completed by the Hospital Data Team** | |
| **Date of decision to refer** |  |
| **Date of appointment** |  |
| **Date of earliest offered appointment (if different to above)** |  |
| **Specify reason if not seen at earliest offered appointment** |  |
| **Periods of unavailability** |  |
| **Booking number (UBRN)** |  |
| **Final diagnosis: Malignant**  **Benign** | |