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| Text  Description automatically generated | **LOWER 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} | |

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| **Faecal Immunochemical Test (FIT) – guidance for Primary Care** | |
| Except for patients presenting with rectal mass or anal mass/ulceration **ALL** patients with suspicious of bowel cancer symptoms (NG12 compatible) **must have a FIT prior to instigation of referral.**  The results should be reviewed by Primary Care to help stratify theneed for and urgency of referral | |
| **Patients presenting with a palpable Abdominal Mass** should undergo FIT and, if locally available,  an urgent, direct access Abdo/pelvis CT\* requested simultaneously to a LGI ‘suspicious of cancer’ referral being generated  (\*if CT not locally available, request urgent Abdo/pelvic USS) | |
| **Patients with a FIT result above threshold (≥ 10)** should be referred via the LGI ‘suspicious  of cancer’ route in accordance with the SYB Optimum LGI Rapid Diagnostic Pathway  protocol and national guidance | |
| **Patients with a FIT result below threshold (< 10) but where specific clinical concerns**  **remain**, pursue Advice and Guidance\* routes (RECOMMENDED)  This will enable your specific clinical concerns to be described and considered in the determination  of on-going clinical management plans  \*Advice and Guidance routes can lead to a Consultant Upgrade on to a ‘suspicious of cancer’  pathway and should be optimised  Alternatively, the patient can be referred via a routine or urgent, non-colorectal cancer pathway | |
| **Iron Deficiency Anaemia with FIT below threshold (< 10)** – Patients should be referred to a dedicated Iron Deficiency Anaemia or Gastroenterology/Colorectal non ‘suspicious of cancer’  pathway (subject to local availability). In the absence of any other symptoms, according to evidence, the risk of LGI or UGI cancer is low | |
| **Patients with a FIT result below threshold (< 10), normal full blood count and no on-going clinical concerns** should be managed in Primary Care and safety netted. The use of a second FIT test may be considered (after 4 weeks) | |
| **Patient meets FIT inclusion criteria**: Please confirm the patient has undergone FIT  and you have reviewed the result prior to instigation of referral (check box for Y) |  |
| **Patient meets FIT exclusion criteria**: Please confirm the patient does not require FIT due to exclusion criteria (check box for Y) |  |
| **FIT result:** ${fobG} | |

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| **NG12 Referral Criteria – ‘suspicious of bowel cancer’ including FIT guidance (tick as appropriate)** | |
| **FIT exclusion**  All ages – Rectal/Anal mass or ulceration |  |
| **FIT inclusion but refer simultaneously – plus, if locally available, request direct access CT abdo/pelvis (or Abdo/pelvic USS where CT not available) at time of referral.**  Abdominal Mass |  |
| **FIT inclusion but await result before referral decision**  All other NG12 ‘suspicious of cancer’ symptom(s) plus FIT result ≥ 10  Aged ≥40y with unexplained weight loss and abdominal pain  Aged ≥50y with unexplained rectal bleeding  Aged ≥60y with:   * + Iron deficiency anaemia *(N.B. in draft guidance NICE defined this as Hb ≤12 in men and Hb ≤11 in women – this was based on primary care research that showed these lower thresholds would pick up more cases – it was removed from final guidance and left to our discretion)*   + Changes in their bowel habit.   <50y and rectal bleeding with any of the following unexplained symptoms or findings:   * + Abdominal pain.   + Change in bowel habit.   + Weight loss.   + Iron deficiency anaemia.   Aged 50y and over and have abdominal pain or weight loss  Aged <60y and have change in bowel habit or iron deficiency anaemia  Aged 60y and over and have anaemia - even in absence of iron deficiency |  |
| **Patient has a FIT result below threshold (< 10) but specific clinical concerns**  **remain**, pursue Advice and Guidance routes (RECOMMENDED).  This will enable your specific clinical concerns to be described and considered in the determination of on-going clinical management plans  Alternatively, the patient can be referred via a routine or urgent, non-colorectal cancer pathway |  |

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| **PLEASE ENSURE a Digital Rectal Examination (DRE) is undertaken and add clinical details and examination findings below (this can be copied from your consultation note)** | |
| ${symptomsAndExaminationFindings} | |
| **Digital rectal examination** | ${digitalRectalExamination} |

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| **Additional clinical information** | |
| Has the patient had a colonoscopy in the last 3 years? | Yes  No  ${colonoscopyResultDetails} |
| I can confirm the patient has the cognitive ability to discuss undergoing colonoscopy | Yes  No |
| ***Patients with a change in bowel habit to looser stools***. I can confirm that a Stool Culture has been performed prior to referral *(but do not delay referral to await result)* | Yes  No  N/A |

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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) U&E result to facilitate efficient pathway next steps.** | |
| **FBC** | ${fbcG} |
| **U&E** | ${renalFunctionG} |
| **Ferritin** | ${ferritin} |
| **FIT (where appropriate)** | ${fobG} |
| **Optional tests** | |
| **LFTs** | ${lftG} |
| **Clotting** | ${clottingG} |
| **TSH** | ${thyroidFunctionG} |
| **Coeliac antibodies** | ${coeliacAntibodies} |
| **Faecal pancreatic elastase** | ${faecalPancreaticElastase} |
| **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** | |