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| Text  Description automatically generated | **LUNG*****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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| **Smoking status** |
| **Never smoker** | **[ ]**  | **Smoker** | **[ ]**  | **Ex-smoker** | **[ ]**  |
| **Smoking cessation education offered?**  | [ ]  Yes [ ]  No [ ]  N/A |

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| **Referral criteria** |
| **Up to date U&Es (within the last 3 months) are required to enable CT Scan with contrast** |
| **CXR suggests possible cancer**  | [ ]   |
| **40 or over with unexplained haemoptysis (Please arrange CXR at time of referral)**  | [ ]   |
| **Normal CXR but significant on-going clinical concerns**  | [ ]   |
| **Underlying chronic respiratory problems – unexplained changes in existing symptoms**  | [ ]   |
| **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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| **Order urgent CXR (within 2 weeks)** |
| **40 or over, never smoked, but 2 or more of the following or**  | [ ]   |
| **40 or over and previously smoked, with 1 or more of the following or**  | [ ]   |
| **Any age with asbestos exposure and 1 or more of the following:**  | [ ]   |
| * **Cough**
 | [ ]   |
| * **Fatigue**
 | [ ]  |
| * **Shortness of breath**
 | [ ]  |
| * **Chest pain**
 | [ ]  |
| * **Weight loss**
 | [ ]  |
| * **Appetite loss**
 | [ ]  |

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| **Consider urgent CXR (within 2 weeks)** |
| **Persistent or recurrent chest infection**  | [ ]   |
| **Finger clubbing**  | [ ]   |
| **Supraclavicular lymphadenopathy or persistent cervical lymphadenopathy**  | [ ]   |
| **Thrombocytosis**  | [ ]   |
| **If chest signs compatible with lung cancer**  | [ ]  |
| **If chest signs compatible with pleural disease**  | [ ]  |

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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) U&E result to facilitate efficient pathway next steps.** |
| **U&E**  | ${renalFunctionG} |
| **CXR**  | ${chestXrayG} |
| **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** [ ]  |