Suspected Urological Cancer – Referral Form

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 Urology	

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:

Smoking Status:

Single Code Entry: Smoking Status

Referral Reason/Letter Text

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If your patient does not meet any of the NICE defined 2WW criteria please liaise (by phone or Advice and Guidance) with a specialist or send them in as an urgent referral. Please do not annotate 2WW forms with your own criteria.

Patient Awareness

Confirm that your patient understands that they have been referred onto a "suspected cancer pathway":	Please select below
Confirm that your patient has received the information leaflet (also available as easy read):	Please select below
Confirm that your patient is available to attend an appointment within 2 weeks of this referral:	Please select below
If, after discussion, your patient chooses to not attend within 2 weeks, when will they be available:	

Please tick any criteria that match the patient's symptoms and give PSA results

Visible haematuria (in adult)	☐
Non-visible haematuria, (adult over 40) (need 2 positive urine dips out of 3, each test separated by 2-3 weeks, a score of 1+ is considered positive)	☐
Solid swellings in the body of the testis	☐
Palpable renal mass	☐
Solid renal tract masses found on imaging	☐
Abnormal feeling prostate on examination (any age) and PSA level ng/ml	☐
PSA over 10ng/ml (after exclusion of UTI) on one occasion in a man with a ten-year life expectancy ng/ml	☐
PSA above age-specific reference range, but below 10ng/ml in a man with a likely ten-year life expectancy (after exclusion of UTI) 1st value ng/ml (date) 2nd value ng/ml (date) **not less than 6 weeks later** **(40-49y: 0-2, 50-59y: 0-3, 60-69y: 0-4, >70y: 0-5 ng/ml)**	☐
A UTI has been excluded (mandatory for 2ww pathway)	☐
Any suspected penile cancer	☐

Additional Information

Please tick to confirm U+Es have been requested (if not done in the last three months) *They are needed to enable rapid MRI scanning*	☐

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Please consider giving patients with raised PSA one of the information sheets

Any additional comments / history of this presentation:

An MRI form is appended to this referral template. It is not for GPs to complete or sign.
It is to help the urologists rapidly order an MRI when they feel that's indicated because most details will have been automatically completed by GP computer systems.

Not all patients need an MRI but it will speed up secondary care investigations if primary care referrers complete blue boxes and secondary care will complete the grey boxes.

Generic Patient Clinical Details

Patient Name: Title Given Name Surname
Date of Birth: Date of Birth
NHS number: NHS Number

Summary Problems List

Problems

Current Repeat Medication List

Medication

Allergies & Sensitivities

Allergies

Most Recent BMI

Single Code Entry: Body mass index

Most Recent Blood Pressure

Blood Pressure

Smoking Status

Other Clinical Relevant Detail (include carer details if relevant)

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YORK TEACHING HOSPITAL NHS TRUST

Urology 2WW Prostate/Pelvis MRI Scan Referral

Authorised referrers **ONLY** must complete **ALL** non "Radiology only" sections on this page

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

Primary care referrers please complete blue boxes	Secondary care complete grey boxes
Patient Information **Patient Name:** Full Name **NHS Number:** NHS Number **DOB:** Date of Birth **Gender:** Gender **Address:** Home Full Address (stacked) **Telephone Number:** Patient Home Telephone **Mobile Number:** Patient Mobile Telephone	Patients need to be able to reliably answer safety questions prior to MRI (about metal foreign bodies and implants etc). If their cognition is impaired and they may not be able to do this extra time is allowed for plain film testing prior to MRI so… ***Is the patient able to independently answer MRI Safety Screening questions?*** Y ☐ N ☐
Examination requested **Prostate / Pelvis** Free text: Patient is on a fast track pathway? ☒ Yes	Does the patient have an implanted device which may be a contraindication to MRI? Y ☐ N ☐ If so, what are they?
Clinical details and diagnosis:	**Is the patient known to have severe renal impairment (defined eGFR <30ml/min/m^2)?** (Mandatory) Yes ☐ No ☐ If **yes EITHER**: provide Egfr (<3 months old) ***eGFR**: Single Code Entry: eGFR using creatinine (CKD-EPI) per 1.73 square metres **OR:** Tick box ☐ to indicate eGFR being ordered Request may not be processed until results are available to us

Disability? Yes ☐ Hearing ☐ Visual ☐ Learning ☐

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

Referring Clinician Requests only accepted from Trust approved referrers - Ionising Radiation (Medical Exposure) Regulations 2000

Responsible Consultant **Date of referral:**

Weight: Single Code Entry: O/E - weight (Mandatory)

For Radiology Use Only

In ☐ Out ☐ List ☐

Authorised by:

Urgent ☐ Soon ☐ Routine ☐

Practitioner:

Operator: Scan type:

Comments:

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

Radiology appointment date & time: