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| **Reference/Priority** |
| Referral Date: | Priority: | NHS Number: |
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| **Patient Details** |
| Title: | Forename(s): | Surname: |
|  |  |  |

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| **Contact Details** |
| Address Line 1: | Address Line 2: | Address Line 3: |
|  |  |  |
| Town: | County: | Postcode: |
|  |  |  |
| Home Phone: | Mobile: | Test Message Consent: |
|  |  |  |
| Email: |  |  |
|  |  |  |

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| **Referrer/Practice Details** |
| Referring GP: | Referrer Code: | Practice Code: |
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| **Clinic Details** |
| Specialty: | Clinic Type: | Named Clinician: |
|  |  |  |

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| **Patient Choice Preferences** |
| Provider 1: | Provider 2: |
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| **Preferences** |
| Vulnerable Patient: | Vulnerable Reason: | Confidential/Silent Referral: |
|  |  |  |
| Preferred Contact Time: | Interpreter Required: | Preferred Language: |
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| **Referral Details** |
| Non-clinical Information for the Booking Team: |
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| Provisional Diagnosis: |
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| Smoking Status: |
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| **Please complete fully:**  |
| Is the patient available to attend an appointment within the next 14 days? Yes [ ]  No[ ]  |
|  |
| Is the patient aware of the possible diagnosis of cancer? Yes [ ]  No[ ]  |
|  |
| SNSP patient information leaflet given? Yes [ ]  No[ ]  |
|  |
| Please confirm that **ALL FILTER INVESTIGATIONS AS IN PATHWAY** have been Yes [ ]  No[ ] Completed **AND** results received. |
|  |
| Patient’s Performance Status: 0 [ ]  Normal activity/well 1 [ ]  Normal activity but symptomatic 2 [ ]  Resting <50% of the day 3 [ ]  Resting >50% of the day 4 [ ]  Bed bound / inability to self-care |
|  |
| Any Additional Comments: |
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| **Referral Information:** |
| **Use CCG, Cancer MDT & LMC agreed**[**Z:\Essential SNSP Documents\SNSP Referral Criteria & Process.docx.pdf**](file:///Z%3A%5CEssential%20SNSP%20Documents%5CSNSP%20Referral%20Criteria%20%26%20Process.docx.pdf)**Flowchart for referral criteria****Please ensure ALL Filter tests are completed prior to referral** **Note:** ***Please use CUP Referral form* if imaging shows a suspicion of cancer and the primary site is not clear clinically or radiologically.** |
|  |

**Please tick the appropriate box below:**

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|  |
| **New unexplained and unintentional weight loss (either documented >5% in three months or** **strong clinical suspicion )** **[ ]**  |
| **New unexplained vague abdominal pain for four weeks or more (less if very significant concern)** **with no associated change in bowel habit** **[ ]**  |
| **New unexplained constitutional symptoms for four weeks or more (less if very significant concern)****Symptoms include; loss of appetite, fatigue, nausea, bloating or malaise** **[ ]**  |
| **GP ‘gut’ feeling’ of cancer diagnosis [ ]** **No diagnosis suggested by initial tests in Primary Care [ ]** **Patient is NOT currently being investigated for the same problem by another specialist team [ ]**

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| **Referral Text:** |
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