|  |  |  |
| --- | --- | --- |
| **Reference/Priority** | | |
| Referral Date: | Priority: | NHS Number: |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **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: |
|  |  |  |

|  |  |
| --- | --- |
| **Patient Choice Preferences** | |
| Provider 1: | Provider 2: |
|  |  |

|  |  |  |
| --- | --- | --- |
| **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: |
|  |
| Provisional Diagnosis: |
|  |
| 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: |
|  |

|  |
| --- |
| **Referral Information:** |
| **Use CCG, Cancer MDT & LMC agreed**  [**Z:\Essential SNSP Documents\SNSP Referral Criteria & Process.docx.pdf**](file:///Z:\Essential%20SNSP%20Documents\SNSP%20Referral%20Criteria%20&%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:**

|  |
| --- |
|  |
| **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**   |  | | --- | | **Referral Text:** | |  | |
|  |