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

|  |
| --- |
| **Patient Details** |
| Title: | Forename(s): | Surname: |
|  |  |  |

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

|  |
| --- |
| **Referrer/Practice Details** |
| Referring GP: | Referrer Code: | Practice Code: |
|  |  |  |

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

|  |
| --- |
| **Referral Details** |
| Non-clinical Information for the Booking Team: |
|  |
| Provisional Diagnosis: |
|  |
| Smoking Status: |
|  |

NB Please note that up to date patient contact details and a telephone number where the patient can be reached during office hours (0830 – 1800) are essential to allow us to offer your patient a date within seven days of your referral

|  |
| --- |
| **Important:** |
| 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[ ]  |
|  |
| 2 week wait patient information leaflet given? Yes [ ]  No[ ]  |
|  |
| 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**["Suspected Upper GI Cancer"](https://northyorkshireccg.nhs.uk/wp-content/uploads/2021/08/suspected-upper-gi-cancer-flowchart.pdf)**Flowchart for referral criteria**

|  |
| --- |
| **Condition Details** (tick appropriate boxes)**:** |
|

|  |  |
| --- | --- |
| **Dysphagia (all ages)** | **[ ]**  |
| **New onset reflux or dyspepsia:****Age >55****Age <55 – See flowchart for appropriate lx** | **[ ]** **[ ]**  |
| **Lesion suggestive of Upper GI Cancer on imaging or endoscopy** | **[ ]**  |

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

 |
|  |