**2WW FIT POSITIVE TELEPHONE ASSESSMENT (LGI) @ CROYDON UNIVERSITY HOSPITAL REFERRAL FORM**

**REFERRAL DATE:**

**A FIT test needs to be positive for this referral form to be used**

**Please book telephone appointment with patient on eRS to transmit this form to CUH and give the patient the patient leaflet.**

**Priority: 2WW, Speciality: 2WW, Clinic type: 2WW Lower GI**

**Service name: 2WW FIT Positive Telephone Assessment (LGI) @ Croydon University Hospital**

**All referrals should be made within 24 hours.**

**Your patient will be triaged and investigated within 2 weeks.**

**PATIENT DETAILS**

**SURNAME:**       **FIRST NAME:**       **TITLE:** 

**GENDER:**       **DOB:**        **AGE:****NHS NO:** 

**ETHNICITY:**        **LANGUAGE:** 

**INTERPRETER REQUIRED**  **TRANSPORT REQUIRED**

**PATIENT ADDRESS:**       **POSTCODE:** 

**DAYTIME CONTACT**🕾**:** 

**HOME**🕾**:**       **MOBILE**🕾**:**       **WORK**🕾**:** 

**EMAIL:** 

**CARER/KEY WORKER DETAILS**

**NAME:**       **CONTACT**🕾**:**       **RELATIONSHIP TO PATIENT:** 

**COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT**

**COGNITIVE**   **SENSORY**  **MOBILITY**   **DISABLED ACCESS REQUIRED**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**SAFEGUARDING**

**SAFEGUARDING CONCERNS**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**GP DETAILS**

**USUAL GP NAME:** 

**PRACTICE NAME:**       **PRACTICE CODE:**  

**PRACTICE ADDRESS:** 

**BYPASS**🕾**:** 

**MAIN**🕾**:**       **FAX:**       **EMAIL:** 

**REFERRING CLINICIAN:** 

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| **PLEASE INDICATE SYMPTOMS FOR 2WW FIT POSITIVE TELEPHONE ASSESSMENT (LGI) @ CROYDON UNIVERSITY HOSPITAL REFERRAL FORM:**  **PLEASE NOTE: To use this referral form patients should have a positive FIT test** | | |
|  | **Any age with suspicious / unexplained abdominal mass** | |
|  | **≥ 40 years with unexplained abdominal pain AND weight loss** | |
|  | **Any age with unexplained iron deficiency anaemia** | |
|  | **≤ 50 years with rectal bleeding with any of the following unexplained symptoms:** | |
|  |  | **Abdominal pain** |
|  |  | **Change in bowel habit** |
|  |  | **Weight loss** |
|  |  | **Iron deficiency anaemia (attach results)** |
|  | **≥ 50 years with unexplained rectal bleeding** | |
|  | **≥ 50 years with unexplained abdominal pain OR weight loss** | |
|  | **Any age with unexplained change in bowel habit** | |
|  | **≥ 60 years with unexplained anaemia even in the absence of iron deficiency** | |
|  | **Referral is due to CLINICAL CONCERNS that do not meet NICE/Pan-London referral criteria (the Primary Care clinician MUST give full clinical details in the additional clinical information’ box at time of referral).**  **Where clinical suspicion of cancer is low, please also consider alternative options for referral which have been agreed locally (e.g. urgent referral, direct access investigations, early diagnosis pathways)** | |

|  |  |
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| **SUITABILITY FOR TELEPHONE TRIAGE/STRAIGHT TO TEST ENDOSCOPY PATHWAY.**  **PLEASE COMPLETE THIS SECTION FOR ALL PATIENTS.**  **The following information establishes if the patient is suitable for telephone triage and the ‘straight to test’ endoscopy pathway. All patients must have up to date renal function (within 3 months) as they may be sent for straight to test CT colonography prior to first outpatient appointment.** | |
|  | **Patient has dementia** |
|  | **Patient has learning disability** |
|  | **Patient has physical impairment that prevents patient being ambulant from a wheelchair** |
|  | **Patient is on anticoagulant or antiplatelet agents (except aspirin)** |
|  | **Patient is unsuitable for telephone triage** |
|  | **Digital rectal examination has been performed (please include findings both positive and negative in ‘additional clinical information’ box below)** |
|  | **Patient has had other gastrointestinal investigations in the last 12 months (abdominal imaging or gastrointestinal endoscopy). Please ensure relevant details are included in the ‘imaging studies/endoscopy studies’ boxes below including name of specialist and hospital where the investigations were performed** |

|  |  |  |
| --- | --- | --- |
| **MANDATORY BOX FOR ALL PATIENTS - WHO PERFORMANCE SCORE**  **Enter score to establish if patient is suitable for straight to test CT scan, endoscopy or ultrasound prior to first outpatient appointment** | | |
|  | **0** | **Fully active, able to carry on all pre-disease performance without restriction.** |
|  | **1** | **Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light housework, office work.** |
|  | **2** | **Ambulatory and capable of all self-care but unable to carry out any work activities.**  **The patient is 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 out any self-care. The patient is totally confined to bed or chair.** |

**Additional clinical information:**

**Personal/relevant patient information:**

**Past history of cancer:**

**Relevant family history of cancer:**

|  |  |
| --- | --- |
|  | **I have discussed the possible diagnosis of cancer with the patient** |
|  | **The patient has been advised and confirmed they will be available for an appointment within the next two weeks** |
|  | **I have counselled the patient regarding the referral process and offered the Colorectal pathway referral patient information leaflet. Offering written patient information increases patient experience and reduces non-attendance. These are available in 11 different languages.**  [Press the <Ctrl> key while you click here to view the](https://www.healthylondon.org/cancer/suspected-cancer-referrals/patient-information-leaflets) Colorectal pathway patient information leaflet |
|  | **This patient has been added to the practice suspected cancer safety-netting system**  [Press the <Ctrl> key while you click here to view t](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/guides/safetynetting)he Croydon FIT Pathway for Suspected Lower GI Cancer FAQ Sheet |

**INVESTIGATIONS**

**Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.**

**ENDOSCOPY STUDIES (in past year) Please include date:** **and location:** 

**IMAGING STUDIES (in past year) Please include date:**       **and location:**

**CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA**

**FAECAL IMMUNOCHEMICAL TEST (Please note a FIT test should have been done, please record all values)**

**FULL BLOOD COUNT (most recent recorded in past 3 months)**

**U&Es (most recent recorded in past 3 months)**

**LFT (most recent recorded in past 3 months)**

**IRON STUDIES (most recent recorded in past 3 months)**

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**