Suspected Cancer in Adults
LUNG (2WW)

NHS Northern Cancer Alliance

Date of Referral:

Name:		DOB:		NHS No	

Attach this form to the e-referral within 24 hours

If ERS not available, please send this form AND 'Referral header sheet' by secure email or FAX

- ☐ The Patient has been informed that this is an urgent referral for suspected cancer
- ☐ The patient is available and willing to attend hospital for tests/appointment within 14 days
- ☐ The patient has been given the 2WW Patient Information Leaflet

Hyperlinks to: NICE GUIDANCE Patient info leaflet including easy read

NICE Guidance

Immediate Referral - DO NOT USE THIS FORM

Speak directly to a Consultant Respiratory Physician or Consider acute admission for patient with:

- **Signs of SVC obstruction (swelling of face/neck/fixed elevation of JVP)**
- **Stridor**

Refer urgently for an appointment within 2weeks, patients with:

☐	Unexplained haemoptysis aged 40 years and older
☐	A chest X-ray where there is a high suspicion for lung cancer
☐	A normal chest X-ray where there is a high suspicion of lung cancer
☐	A history of asbestos exposure and recent onset of chest pain, shortness of breath or unexplained systemic symptoms where a chest X-ray indicates pleural effusion, pleural mass or any suspicious lung pathology

Before Referral

Offer urgent Chest X-ray (to be performed within 2 weeks) **to assess for lung cancer in patients over 40:**
If they have 2 or more of the following unexplained symptoms OR
If they have ever smoked and have one or more of the following unexplained symptoms:

▷Cough ▷Fatigue ▷Shortness of breath ▷ Chest pain ▷Weight loss ▷Appetite loss

Consider an urgent chest X-ray in people aged 40 and over with any of the following:

▷Persistent or recurrent chest infection ▷Finger clubbing ▷Thrombocytosis
▷Supraclavicular lymphadenopathy or persistent cervical lymphadenopathy

Reason for Referral - Compulsory

Name: DOB: NHS No

Recent CXR: ☐ **YES** ☐ **NO** If yes, DATE:

Recent CT scan ☐ **YES** ☐ **NO** If yes, DATE:

Weight:

Essential Information

As some patients will be directed to other investigations before the clinic appointment

Performance Status			
	☐	0	Fully active
	☐	1	Cannot carry out heavy physical work
	☐	2	Up and about more than half the day and can look after yourself
	☐	3	In bed or sitting in a chair for more than half the day and need help in looking after yourself
	☐	4	In bed or a chair all the time and need a lot of looking after

Please indicate COVID 19 risk:		
☐	**Standard**	No co-morbidities
☐	**Vulnerable**	Co-morbidities/frailty
☐	**Shielded**	In the shielded group because of high risk from COVID 19 infection

Description	**Y**	**N**	**Description**	**Y**	**N**
Anticoagulants including NOACs	☐	☐	Metformin	☐	☐
Antiplatelet e.g. Clopidogrel, prasugrel	☐	☐	Insulin/Sulfonylureas	☐	☐

Cardiac:	☐ Poorly controlled Angina/MI **within 3 months** ☐ Prosthetic valve replacement, previous SBE or vascular graft **within one year**
Diabetes :	☐

History of IHD, Diabetes and CKD:

NB: Information below only displays latest recording, Full list is displayed in Patient Medical History

: Ischaemic heart disease...

Blood Test Result in the last ONE month

If blood test results do not appear below but have been requested please 'X' the box and enter date

LFTs:	☐ **Requested Date:**	
	Result within 1 months REQUIRED	**Latest Result**
Bilirubin		
Alkaline Phosphatase		
ALT		
Albumin		

FBCs	☐ **Requested Date:**	
	Result within 1 month REQUIRED	**Latest Result**
Haemoglobin		
WCC		
MCV		
Platelets		

Name: DOB: NHS No

U&Es	☐ **Requested Date:**	
	Result within 1 months REQUIRED	**Latest Result**
Sodium		
Potassium		
Urea Level		
Creatinine		
Adj Calcium		

eGFR result within 1 month **REQUIRED** ☐ **Requested** **Date:**

eGFR latest result

ANY allergies: (including contrast)

Allergies

Name: DOB: NHS No

Referrer details

Name of Referrer:		Date of Referral:	
Referring organisation Tel: Email: Fax:		**GP details** Tel: Fax:	
Name of GP to address correspondence to, if different to accountable GP:			

Patient details

Name:		Address:	
Gender:			
DOB and Age	Age:		
NHS number:			
Patient Contacts	Home:	Mobile:	
	Work:	Email:	
	Carer/Advocate: The patient has confirmed the following person should be included in correspondence – Name: Contact Details:		
Contact Consent:	☐ Can leave message on answer machine ☐ Can contact by text ☐ Can contact by Email	NB: Not all services use Texts or Emails as a method of communication.	
Ethnicity:			
Interpreter:	☐ **Yes** **Language:**		
Accessibility Needs:	☐ Wheelchair access ☐ Deaf ☐ Registered Blind ☐ Learning Disability ☐ Other disability needing consideration ☐ Accompanied by Carer		
Risks:	☐ Vulnerable Adult (details below, if any recording in last 3 years) Other:		
Other:			

Accessible Information

Communication Support: Uses a legal advocate...
Professional required: Interpreter needed - British Sign Language...
Contact method: Requires contact by telephone...
Information format: Requires information verbally...

If you have any problem with this form or suggested changes, please control & click here to open direct email. (NB: NOT TO BE USED FOR REFERRING A PATIENT) 2WW NCA Lower GI Referral Form – EMIS Web V4 updated Gateshead April 2018

To be completed by the Data Team (Insert Dates)
Received: / / **First Appointment booked:** / /
First Appointment date: / / **1st seen:** / /
Specify reason if not seen on 1st appointment:
Diagnosis: **Malignant** ☐ **Benign** ☐