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| Suspected gynaecological cancer 2 week wait referral |

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| Date of decision to refer: |  | Date referral received at Trust: |  |

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| Patient Details | Surname: First Name: Title: |
| Gender: DOB: / / NHS Number: |
| Ethnicity: Language: |
| Interpreter required: Transport required: |
| Patient Address:  Postcode: |
| Contact numbers:  Home: Mobile: Email: |
| Practice Details | Registered GP Name: |
| Practice Name : |
| Direct line to the practice (Bypass) : |
| Main: Fax: Email: |
| Referring Clinician: |

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| **SPECIFIC 2 WEEK WAIT REFERRAL INFORMATION**   |  | | --- | | **Ovarian**  ☐Imaging suspicious of ovarian cancer  ☐On examination ascites &/or pelvic/abdominal mass (not obviously fibroids) | | **Endometrial**  ☐USS suspicious of cancer  ☐Post-menopausal bleeding (>12m after LMP)  ☐Irregular bleeding persists 6w after stopping HRT or bleeding on tamoxifen after significant amenorrhoea  \* *Please note asymptomatic endometrial thickening without other symptoms should be referred routinely* | | **Cervical**  ☐Destructive or obvious growth on or replacing cervix | | **Vulval**  ☐Unexplained vulval lesion, lump, ulceration or bleeding suspicious of cancer | | **Vaginal**  ☐Unexplained palpable mass in the vagina (not due to prolapse) |   **Please describe why this patient may have cancer (ESSENTIAL)**   |  | | --- | |  |   **Blood results (ESSENTIAL)**   |  | | --- | | Please ensure the following are requested prior to clinic date (U&Es must be within 4 weeks): **Creatinine \_\_\_\_ eGFR \_\_\_\_ *CA125* \_\_\_\_***for suspected ovarian cancer* | | |
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| ☐ | **The patient is aware that this is a 2 week wait referral to exclude gynaecological cancer** |
| ☐ | The patient has been provided with a cancer pathway leaflet |
| ☐ | The patient is aware and able to attend an outpatient appointment within the next two weeks |

**Please tick YES if any of the following apply to your patient:**

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| ☐ | Patient has cognitive impairment that may affect their mental capacity for consent.  If yes, please confirm date best interests meeting completed: \_\_/\_\_/\_\_\_\_ |
| ☐ | Patient has significant mobility impairment – please tick if hoist is required |
| ☐ | Patient has significant sensory impairment (specify): |
| ☐ | Patient will require an interpreter (specify): |

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| Clinical Information | **WHO Performance Status (please circle)** | |
| **0**☐  **1**☐  **2**☐  **3**☐  **4**☐ | Fully active  Restricted in physically strenuous activity but ambulatory and able to carry out light work  Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours  Capable of only limited self-care, confined to bed/chair 50% of waking hours  No self-care, confined to bed/chair 100% |
| **Details of other significant medical history:** | |
| **Anticoagulation and / or antiplatelet** **medication** – please state indication, medication taken and latest INR if applicable:  **List or attach regular medication:** | |