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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**

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| **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)**

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**Blood results (ESSENTIAL)**

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| 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:** |