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| Suspected (non-prostate) urological cancer 2 week wait referral |

**\*Please use separate prostate cancer form for referrals with suspicion of prostate cancer**

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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 FAST TRACK INFORMATION**

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| **Bladder/Renal Tract**☐ >45y with unexplained visible haematuria without UTI or visible haematuria that persists or recurs after successful treatment of UTI☐ >60y with unexplained non-visible haematuria and either dysuria or raised white cell count |
| **Testicular**☐ Non-painful enlargement/ ☐ Change in shape/ ☐ Change in texture |
| **Penile**☐ Mass/ ☐ Ulcerated lesion/ ☐ Unexplained or persistent symptoms affecting the glans or foreskin  |

**Additional clinical information**

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**Blood results (ESSENTIAL)**

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| Please ensure the following recent blood results are available (U&Es must be within 4 weeks):**Hb \_\_\_\_\_ Na \_\_\_\_\_ K \_\_\_\_ eGFR \_\_\_\_ *PSA*** *(if available)*  |

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

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| ☐ | **The patient is aware that this is a 2 week wait referral to exclude urological 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 |
| ☐ | The patient is aware they may have imaging prior to seeing a clinician. |
| ☐ | 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 |
| ☐ | 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:** |