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| Suspected lung 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:  |

**SPECIFIC 2 WEEK WAIT REFERRAL INFORMATION:**

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| **Symptoms of stridor or superior vena cava obstruction need immediate admission** |
| ☐ | Abnormal CXR report suggestive of cancer |
| ☐ | >40y with Normal CXRand **unexplained** haemoptysis |
| ☐ | Normal CXR, but clinical suspicion - please describe symptoms |

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| **Symptoms and reason for referral:*****Please include smoking status, history, and duration of symptoms,*** **Please tick if any of the following apply:**☐ history of asbestos exposure☐ family history of lung cancer |
| **Blood results (ESSENTIAL)**

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| Please ensure the following recent blood results are available (U&Es must be within 4 weeks):**Platelets** ☐ **Ca** ☐ **Clotting** ☐ **Bone** ☐ **LFT** ☐ **eGFR** ☐ |

**Please ensure the following:** |
| ☐ | **The patient is aware that this is a 2 week wait referral to exclude lung cancer** |
| ☐ | Patient advised they may go straight to test with a CT scan prior to being seen in clinic |
| ☐ | 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 |
| ☐ | Patient has significant sensory impairment (specify): |
| ☐ | Patient will require an interpreter (specify): |

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| Clinical Information  | **WHO Performance Status (please tick)** |
| **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:****Is patient diabetic?** ☐ Yes ☐ No |
| **Anticoagulation and / or antiplatelet** **medication** – please state indication, medication taken and latest INR if applicable:**List or attach regular medication:****Is patient on metformin?** |