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| **Suspected prostate 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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| * **This referral form is for suspected PROSTATE CANCER ONLY.** * For other suspected urological cancers please use the Urology 2 Week Wait referral form * **FULLY COMPLETED** forms will assist in arranging the most appropriate clinical assessment for the patient * Please ensure blood tests arranged and/or available |

**Prostate referral criteria**

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| **☐** | **Prostate feels abnormal on DRE** |
| **☐** | **PSA raised above age specific range** (see information for referrers below) |
| **☐** | **Repeat PSA remains elevated (**see information for referrers below)  *please include both PSA values in blood results section* |
| **NB:** PSA can be artificially high due to prostate inflammation, so please ensure that a UTI is excluded and consider other causes (e.g. recent catheterisation; recent biopsy etc.) When requesting a PSA please advise patient to avoid vigorous exercise and avoid ejaculation 48 hours prior to testing. | |

**Information for Referrers**

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| A normal PSA does NOT EXCLUDE prostate cancer and a raised PSA may not be due to prostate cancer. Repeating a PSA helps guide prostate cancer risk and facilitates more efficient and patient centric pathways ie the timing of further investigations.  (*see additional clinical information*)– refer.  **Consider repeat PSA after 6 weeks prior to referral if:**   * PSA greater than age specific range but below 10ng/ml and no risk factors (*see additional clinical information*). * If recent infection or instrumentation   **Upon repeat PSA:**   * If PSA returns to within normal range review patient and consider routine/urgent referral if patient has troublesome lower urinary tract symptoms. Otherwise consider monitoring in primary care or seeking advice and guidance if concerned. * If PSA remains elevated, please refer on 2WW pathway   **Normal age specific PSA ranges:**   * Age 50 – 69: 0.0 - 2.9 * Age 70 – 79: 0.0 - 4.9 * Age 80 and over: 0.0 - 9.9 |

**Blood results (ESSENTIAL):**

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| Please ensure the following recent blood results are arranged/ available (U&Es must be within 4 weeks):  **Hb \_\_\_\_\_\_ eGFR \_\_\_\_\_ Urine Dipstick \_\_\_\_\_\_ PSA 1st \_\_\_\_\_\_ 2nd PSA (***if applicable***) \_\_\_\_\_\_\_** |

**WHO performance status (ESSENTIAL):**

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| 0 **☐** | Fully active |
| 1 **☐** | Restricted in physically strenuous activity but ambulatory and able to carry out light work |
| 2 **☐** | Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours |
| 3 **☐** | Capable of only limited self-care, confined to bed/chair 50% of waking hours |
| 4 **☐** | No self-care, confined to bed/chair 100% |
| **NB: Consider a routine / urgent referral for WHO performance status 3&4 if appropriate** | |

**Additional clinical information**

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| **Certain groups at a higher risk of prostate cancer, please advise if this applies to your patient:** | |
| **☐** | Family history of prostate cancer (especially if in first degree relative under 60 yrs of age) |
| **☐** | Family history of breast or ovarian cancer (especially if BRCA related) |
| **☐** | Afro-Caribbean descent |

**Please tick 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. |
| ☐ | The patient has contra-indications to MRI use: e.g. pacemaker, metallic foreign body (joint / eye) |

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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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| **Details of other significant medical history:** |
| Does patient have diabetes? ☐ Yes ☐ No  Does patient use metformin? ☐ Yes ☐ No |
| **Anticoagulation and / or antiplatelet medication:** (*please state indication and medication taken*) |
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| **List or attach regular medication: (ESSENTIAL)** |
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