|  |
| --- |
| **Suspected prostate cancer 2 week wait referral** |

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

|  |  |
| --- | --- |
| **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:  |

|  |
| --- |
| * **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**

|  |  |
| --- | --- |
| **☐** | **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**

|  |
| --- |
| 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):**

|  |
| --- |
| 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):**

|  |  |
| --- | --- |
|  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**

|  |
| --- |
| **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:**

|  |  |
| --- | --- |
| ☐ | 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) |

|  |  |
| --- | --- |
| ☐ | 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): |

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