

PATIENT DETAILS			
Surname:	[MERGED FIELD]	First Name:	[MERGED FIELD]
D.O.B.:	[MERGED FIELD]	Gender:	[MERGED FIELD]
Age:	[MERGED FIELD]	NHS No.:	[MERGED FIELD]
Address:	[MERGED FIELD]		
Post code:	[MERGED FIELD]		
Home Tel.:	[MERGED FIELD]	Mobile:	[MERGED FIELD]
Other Tel.:		Other Tel Name:	
Interpreter required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	First Language:

GP DETAILS	
Name:	[MERGED FIELD]
Code:	[MERGED FIELD]
Address:	[MERGED FIELD]
Post code:	[MERGED FIELD]
Tel. No.:	[MERGED FIELD]
E-mail:	[MERGED FIELD]

PATIENT ENGAGEMENT AND AVAILABILITY			
<p>I confirm the following: I have discussed the possibility that the diagnosis may be cancer; I have provided the patient with a 2WW referral leaflet and advised the patient that they will need to attend an appointment within the next two weeks</p>			
GP Name:		Date of decision to refer (dd/mm/yy):	

REFERRAL CRITERIA	
<p>Please note - appending a FIT result to this referral enables patients to be prioritised to the correct service and supports the provision of the right care, at the right time, in the right place. FIT should be offered even if the person has previously had a negative FIT result through the NHS bowel cancer screening programme. Please refer with a FIT result in line with NICE DG56</p>	
<p><input type="checkbox"/> FIT value meets NICE recommended threshold for referral (i.e. FIT ≥ 10):</p>	
<p>FIT value [auto-populate or enter text]</p>	
<p>Reason FIT was requested (based on NICE guidelines for adults, NG12, updated 2023):</p>	
<p><input type="checkbox"/> Abdominal mass</p> <p><input type="checkbox"/> change in bowel habit</p> <p><input type="checkbox"/> Iron Deficiency Anaemia (IDA)</p> <p><input type="checkbox"/> ≥ 40years with unexplained weight loss and abdominal pain</p> <p>< 50 years with rectal bleeding AND any one of the following unexplained symptoms (please check those that apply)</p> <p><input type="checkbox"/> Abdominal pain or</p> <p><input type="checkbox"/> Weight loss</p> <p>≥ 50 years with any of the following unexplained symptoms (please check those that apply)</p> <p><input type="checkbox"/> Rectal bleeding or</p> <p><input type="checkbox"/> Abdominal pain or</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> ≥ 60 years with anaemia even in the absence of iron deficiency</p>	
<p><input type="checkbox"/> Strong clinical suspicion of colorectal cancer but FIT value is <10: (Please consider other potential tumour sites including upper GI, gynaecological and others before referring to lower GI)</p>	
<p>FIT value [auto-populate or enter text]</p>	
<p>Reason for referral:</p> <p><input type="checkbox"/> Persistent /recurrent anorectal bleeding</p> <p><input type="checkbox"/> Strong clinical concern of cancer because of ongoing unexplained symptoms (please state reason here)</p>	

FIT result NOT required before making suspected cancer referral (please indicate reason):

- Rectal mass
- Anal mass
- Unexplained anal ulceration
- Unexplained abdominal mass, not gynaecological
- Patient unable to complete a FIT due to physical/mental constraints but has concerning colorectal symptoms

Please note: If your patient is symptomatic (regardless of age) and the FIT is below threshold (<10) then, if clinically appropriate, further options to consider include:

- Refer on a routine/urgent colorectal pathway
- Refer to a local Non Site-Specific service (NSS), if available
- Consider advice and guidance

REFERRAL WHERE NICE NG 12 GUIDANCE IS NOT MET

NOTE: Whilst guidance assists the practice of healthcare professionals, they do not replace their knowledge, skills or clinical judgement. Tick the following boxes if you are unsure if a patient meets the NICE criteria

I am very concerned my patient has cancer but they do not meet the NICE NG 12 criteria

If yes, please state why you have suspicions:

CLINICAL INFORMATION

NOTE: Please ensure urgent blood tests are undertaken for FBC, Ferritin, electrolytes and creatinine

Relevant clinical details including past history of cancer, family history and examination findings:

FBC	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Results attached	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ferritin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Results attached	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Electrolytes and creatinine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Results attached	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anticoagulation	Yes <input type="checkbox"/>				
Cognitive Impairment (e.g. dementia/learning disability, memory loss etc.)	Yes <input type="checkbox"/>				
Is a hoist required to examine the patient?	Yes <input type="checkbox"/>				

PATIENT'S WHO PERFORMANCE STATUS

<input type="checkbox"/>	0	Able to carry on all normal activity without restriction
<input type="checkbox"/>	1	Restricted in physically strenuous activity but able to walk and do light work
<input type="checkbox"/>	2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
<input type="checkbox"/>	3	Symptomatic and in a chair or in a bed for greater than 50% of the day but not bedridden
<input type="checkbox"/>	4	Completely disabled; cannot carry out any self-care; totally confined to bed or chair

ADDITIONAL GP GUIDANCE

NOTE: If significantly compromised by other co-morbidities or with limited life expectancy consider a discussion with the patient and carer regarding whether investigation is necessary

PATIENT CLINICAL INFORMATION FROM MERGED GP ELECTRONIC RECORDS	
Allergies:	[MERGED FIELD]
Active Problems:	[MERGED FIELD]
Investigations:	[MERGED FIELD]
Significant past history:	[MERGED FIELD]
Current medication:	[MERGED FIELD]
Repeat medication:	[MERGED FIELD]