

SUSPECTED LUNG CANCER REFERRAL FORM

Referrer Details	Patient Details		
Name:	Forename:	Surname:	DOB:
Address:	Address:		Gender:
			Hospital No.:
			NHS No.:
Tel No:	Tel No. (1):	Tel No. (2):	Please check telephone numbers
Email:	Carer requirements (has dementia or learning disabilities)?		
Decision to Refer Date:	Translator Required: Yes <input type="checkbox"/> No <input type="checkbox"/> Language:		Does the patient have the capacity to consent? Yes <input type="checkbox"/> No <input type="checkbox"/> Mobility:

Level of concern

☐ I think it is likely that this patient has cancer, and would like the patient to be investigated further even if the first test proves negative, including a Consultant to Consultant referral if deemed appropriate. All non-site specific symptoms (e.g. iron deficiency anaemia, unexplained weight loss) are listed in the clinical details section below.

Clinical details

Please detail your conclusions and what needs to be excluded, or attach a referral letter.

☐ Patient on anticoagulants (please specify which)

Lung cancer or mesothelioma

☐ Chest X-ray findings suggest lung cancer or mesothelioma (including pleural effusion and slowly resolving consolidation). Location of X-ray

Chest X-ray should be no more than 3 weeks old

☐ Aged 40 and over with unexplained haemoptysis

Please arrange a chest X-ray to take place in next 48 hours

For minor or resolved haemoptysis without other symptoms suggestive of lung cancer, consider a non-urgent chest X-ray

☐ Normal chest X-ray but with a high index of suspicion

Up to 25% of chest X-rays can be falsely negative in lung cancer, so if the clinical suspicion is high, or there is clinical lymphadenopathy or finger clubbing, refer urgently to the fast track lung cancer service.

Has the patient had a recent CT scan?

☐ Yes (please give location of scan)

☐ No, please arrange this

Please ensure the following recent blood results are available (less than 2 weeks old):

FBC, eGFR, clotting, U&E, LFT, bone profile

Lung Function if available:

FEV1 ____

% predicted ____

Anticoagulation

Please provide details and latest INR

Smoking status	WHO Performance Status: <input type="checkbox"/> 0 Fully active <input type="checkbox"/> 1 Able to carry out light work <input type="checkbox"/> 2 Up and about greater than 50% of waking time <input type="checkbox"/> 3 Confined to bed/chair greater than 50% <input type="checkbox"/> 4 Confined to bed/chair 100%
BMI if available	

Please confirm that the patient has been made aware that this is a suspected cancer referral: ☐ Yes ☐ No

Please confirm that the patient has received the two week wait referral leaflet: ☐ Yes ☐ No

Please provide an explanation if the above information has not been given:

If your patient is found to have cancer, do you have any information which might be useful for secondary care regarding their likely reaction to the diagnosis (e.g. a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological or emotional readiness for further investigation and treatment?

Date(s) that patient is unable to attend within the next two weeks

For patients to be managed in a timely way to any eventual treatment, we aim to see them within 10 days of receiving this referral. Please ensure the patient understands this expectation and the clinical importance of making themselves available for urgent assessment.

Please attach additional clinical issues list from your practice system

Details to include:
 Current Medication, significant issues, allergies, relevant family history, alcohol status and morbidities

For hospital to complete UBRN: Received date:
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