Suspected Cancer of Unknown Primary (MUO)

Please create and process referral request via Gateway

Reference/Priority

Referral Date:	Priority:	NHS Number:
<Specific Referral Out Details>	2WW	<NHS number>

Patient Details

Title:	Forename(s):	Surname:
<Patient name>	<Patient name>	<Patient name>
Date of Birth:	**Gender:**	**Ethnicity:**
<Date of birth>	<Gender>	<Ethnicity>

Contact Details

Address Line 1:	Address Line 2	Address Line 3:
<Patient address>	<Patient address>	<Patient address>
Town:	**County:**	**Postcode:**
<Patient address>	<Patient address>	<Patient address>
Phone:	**Mobile:**	**Text Message Consent:**
<Patient Contact Details>	<Patient Contact Details>	No
Email:		
<Patient Contact Details>		

Referrer/Practice Details

Referring Name:	Referrer Code:	Practice Code:
<Specific Referral Out Details>	<Specific Referral Out Details>	<Organisation Details>

Referral Details

Specialty:	Clinic Type:	Named Clinician:
2WW	2WW Cancer of Unknown Primary	

Patient Choice Preferences

Provider 1:	Provider 2:
<Recipient details>	

Preferences

Assistance Required:	Assistance Notes:	Confidential/Silent Referral:
No		No
Preferred Contact Time:	**Interpreter Required:**	**Preferred Language:**
	No	<Main spoken language>

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Referral Details

Non-clinical information for the booking team:

Provisional Diagnosis:

<Specific Referral Out Details>

Smoking Status Readcode:

<Diagnoses>

Referral Reason/Letter Text

<Specific Referral Out Details>

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If your patient does not meet any of the NICE defined USC criteria please liaise (by phone or Advice and Guidance) with a specialist or send them in as an urgent referral. Please do not annotate USC forms with your own criteria.

Patient Awareness

Confirm that your patient understands that they have been referred onto a "suspected cancer pathway":	Unknown
Confirm that your patient has received the information leaflet	Unknown
Confirm that your patient is available to attend an appointment within 2 weeks of this referral**	Unknown
Confirm that the patient's renal function (Urea and electrolytes) has been requested and the patient is aware to have the sample taken urgently, to expedite the request for CT Thorax, abdomen and pelvis with contrast:	Unknown

**If, after discussion, your patient chooses to not attend within 2 weeks, when will they be available:

Please attach all imaging reports

Use this form for: (tick appropriate boxes)

Multiple lung metastases on CXR/CT (unless Radiology indicates lung primary)	☐
Multiple brain metastases on CT/MRI	☐
Multiple liver metastases on USS/CT/MRI	☐
Multiple bone metastases on XR/CT/MRI/bone scan (**PSA not raised**)	☐
Widespread peritoneal infiltration +/-ascites on USS/CT (**CA125 not raised**)	☐
Other disseminated disease on scan and no site of primary identified (discuss with oncology)	☐

For advice please contact Oncology on call or Acute Oncology Nurses on 01904 724519

An alternative referral form should be used for the following results:

- Radiology indicates lung primary - use **Suspected Lung Cancer** form
- Multiple bone metastases on XR/CT/MRI/bone scan **(PSA raised)** - use **Suspected Urological Cancer** form
- Widespread peritoneal infiltration +/-ascites on USS CT **(CA125 raised)** - use **Suspected Gynaecological Cancer** form

Please give indication of patient's performance status (tick one of the following)

0 - Normal activity/well	☐

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1 - Normal activity but symptomatic	☐
2 - Resting but <50% of the day	☐
3 - Resting >50% of the day	☐
4 - Bed bound/limited mobility for ADL	☐

Family History

<Family History(table)>

Active Problems

<Problems(table)>

Summary

<Summary(table)>

Significant Past

<Problems(table)>

Current Repeat Medication

<Medication(table)>

Acute Medication (last 3mths)

<Medication(table)>

Measurements

BP (last 3):
<Last 3 BP Reading(s)(table)>

Weight (last 3):
<Numerics>

Height (last 3):
<Numerics>

BMI (last 3):
<Numerics>

Oxford Knee Score (last 3):
<Numerics>

Allergies

<Allergies & Sensitivities(table)>

Lab Results

<Pathology & Radiology Reports(table)>

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