Suspected Urological Cancer – Referral Form

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 Urology	

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":	Please select below
Confirm that your patient has received the information leaflet	Please select below
Confirm that your patient is available to attend an appointment within 2 weeks of this referral:	Please select below

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

Please tick any criteria that match the patient's symptoms and give PSA results

Unexplained visible haematuria (adult over 45) where a UTI has been excluded or persists or recurs after treatment of UTI	☐
Non-visible haematuria (aged 60 or over) AND either dysuria or raised white cell count on a blood test	☐
Solid swellings in the body of the testis	☐
Palpable renal mass	☐
Solid renal tract masses found on imaging	☐
Abnormal feeling prostate on examination (any age) and PSA level ng/ml	☐
PSA over 10ng/ml (after exclusion of UTI) on one occasion in a man with a ten-year life expectancy ng/ml	☐
PSA above age-specific reference range, but below 10ng/ml in a man with a likely ten-year life expectancy (after exclusion of UTI) 1st value ng/ml (date) 2nd value ng/ml (date) **not less than 6 weeks later** **(40-49y: 0-2, 50-59y: 0-3, 60-69y: 0-4, >70y: 0-5 ng/ml)**	☐
A UTI has been excluded (mandatory for 2ww pathway)	☐
Any suspected penile cancer	☐

Additional Information

Please tick to confirm U+Es have been requested (if none done in the last three months) *They are needed to enable rapid MRI scanning*	☐

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Please consider giving patients with raised PSA one of the information sheets here

Any additional comments / history of this presentation:

An MRI form is appended to this referral template. It is not for GPs to complete or sign.
It is to help the urologists rapidly order an MRI when they feel that's indicated because most details will have been automatically completed by GP computer systems.

Not all patients need an MRI but it will speed up secondary care investigations if primary care referrers complete blue boxes and secondary care will complete the grey boxes.

Generic Patient Clinical Details

Patient Name: <Patient Name>
Date of Birth: <Date of Birth>
NHS Number: <NHS number>

Summary Problem List

<Problems(table)>

Current Repeat Medication List

<Medication(table)>

Allergies & Sensitivities

<Allergies & Sensitivities(table)>

Most Recent BMI

<Latest BMI>

Most Recent Blood Pressure

<Latest BP>

Smoking Status

Other Clinical Relevant Detail (include carer details if relevant)

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YORK TEACHING HOSPITAL NHS TRUST

Urology 2WW Prostate/Pelvis MRI Scan Referral

Authorised referrers **ONLY** must complete **ALL** non "Radiology only" sections on this page

WARNING - Incomplete or illegible requests could delay this examination or result in an incomplete investigation

Primary care referrers please complete blue boxes	Secondary care complete grey boxes
Patient Information **Patient Name:** <Patient Name> **NHS Number:** <NHS number> **DOB:** <Date of Birth> **Gender:** <Gender> **Address:** <Patient Address> **Telephone Number:** <Patient Contact Details> **Mobile Number:** <Patient Contact Details>	Patients need to be able to reliably answer safety questions prior to MRI (about metal foreign bodies and implants etc). If their cognition is impaired and they may not be able to do this extra time is allowed for plain film testing prior to MRI so… **Is the patient able to independently answer MRI Safety Screening questions?** Y ☐ N ☐
Examination requested **Prostate / Pelvis** Free text: Patient is on a fast track pathway? ☒	**Does the patient have an implanted device which may be a contraindication to MRI?** Y ☐ N ☐ **If so, what are they?**
Clinical details and diagnosis:	**Is the patient known to have severe renal impairment (defined eGFR <30ml/min/m^2)?** (Mandatory) Yes ☐ No ☐ If yes **EITHER:** provide eGFR (<3 months old) ***eGFR: <Numerics>** **OR:** tick box ☐ to indicate eGFR being ordered Requests may not be processed until results are available to us.
Disability? Yes ☐ Hearing ☐ Visual ☐ Learning ☐ **Please describe mobility:** Walking ☐ Trolley ☐ Chair ☐ Bed ☐ Hoist ☐ O_2 ☐	
Referring Clinician Requests only accepted from Trust approved referrers - Ionising Radiation (Medical Exposure) Regulations 2000 **Responsible Consultant:** **Date of referral:**	
Weight: <Latest Weight> (Mandatory)	
For Radiology Use Only Authorised by: Practitioner: Operator: Comments: IV Contrast: **Y** ☐ **N** ☐ Radiology appointment date & time:	In ☐ Out ☐ List ☐ **U**rgent ☐ **S**oon ☐ **R**outine ☐ Scan type: Oral Contrast: **Y** ☐ **N** ☐