

**Nottingham NHS Treatment Centre**

**Lower gastrointestinal**

Z013: Patient referral

IMPORTANT: Please state which location your patient wishes to be seen at:

Nottingham City Hospital [ ]  Nottingham NHS Treatment Centre [ ]

If no appointment is available using the e referrals please select defer to provider.

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| **Section 1 Patient information (Please complete in BLOCK CAPITALS)**  |
| Surname:       First name:      Mr [ ]  Miss [ ]  Mrs [ ]  Ms [ ]  Other:      Date of birth:       | Date of referral:       NHS number:      UBRN:      Home telephone number:        |
| Address:      Postcode:  | Mobile / daytime telephone number:       Transport: Yes [ ]  No [ ]  Mobility:       Interpreter: Yes [ ]  No [ ]  Ethnicity:       Language:        |
| **Section 2 Practice information (Please use practice stamp if available)**  |
| Referring GP:        | Locum: Yes [ ]  No [ ]   |
| Practice address:      Postcode:        | Telephone:       Fax:       |
| **Section 3 Clinical information (please ✓all applicable entries)** **Please enclose print outs of CURRENT medications and PAST MEDICAL HISTORY**  |
| **All ages** [ ]  Definite, palpable right sided abdominal mass [ ]  Definite, palpable rectal (not pelvic) mass **AND** [ ]  patients who are men of any age with unexplained iron deficiency anaemia and a haemoglobin of 11g/100 ml or below [ ]  patients who are non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin of 10 g/100 ml or below | **Over 40 years** [ ]  Rectal bleeding WITH a change of bowel habit towards  looser stools and/or increased frequency ≥6 weeks **Over 60 years** [ ]  Rectal bleeding persisting ≥ 6 weeks WITHOUT a change in bowel habit or anal symptoms (e.g. soreness,  discomfort, itching, prolapse, pain) [ ]  Change in bowel habit to looser stools and/or more frequent stools persisting ≥ 6 weeks WITHOUT rectal bleeding  |
| Your patient may go straight to a diagnostic test for example, colonoscopy, flexi-sigmoidoscopy.* **In your opinion, would this patient be suitable to go straight to a diagnostic test?** Y **[ ]** N [ ]
* **Have you told the patient they may go straight to a diagnostic test?** Y [ ]  N [ ]
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| **Section 4 Past medical history - Mandatory** |
| CHARLSON COMORBIDITY SCORE (Tick all those that apply)Acute myocardial infarction/IHD [ ]  Peptic Ulcer [ ]  BMI >30 [ ] Cerebrovascular accident [ ]  Peripheral vascular disease/AAA [ ]  BMI >35 [ ]  Congestive Heart Failure [ ]  Chronic Pulmonary Disease [ ]  BMI>40 [ ] Connective tissue disorder [ ]  Solid Cancer (within 5 years) [ ]  Systemic steroids [ ]  Dementia [ ]  Metastatic Cancer [ ]  Excess ETOH [ ] Diabetes [ ]  Paraplegia [ ]  Smoking [ ]  Diabetes complications [ ]  Renal Disease (non-diabetic) [ ]  Liver disease [ ]  HIV [ ] Severe liver disease [ ]  |
| **Section 5 Medication - Mandatory** |
|      Is your patient taking any of the following:Warfarin [ ] Clopidogrel [ ] If YES please clarify indication:      Is your patient on insulin? Y [ ]  N [ ]  Is your patient on Metformin? Y [ ]  N [ ]  |
| **Section 6 Additional clinical details - Mandatory** |
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| *Recent (within last 3 months)* eGFR (     ) on Date (     )Hb (     ) on Date (      )Ferritin (     ) on Date (     )  |

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| **Section 7 Performance status - Mandatory** |
| ECOG PERFORMANCE STATUS (please tick one of the following statements about the patient)[ ]  0 – Fully active, able to carry on all pre-disease and performance without restriction[ ]  1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g light house work, office work[ ]  2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours [ ]  3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours[ ]  4 – Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair. |

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| Discussed urgent suspected cancer referral with patient: Yes [ ]  No [ ]  |
| Is the patient aware they have been referred on the “2 Week Wait” pathway: Yes [ ]  No [ ]   |
| Does the patient have any holiday plans within the next 2 months: Yes [ ]  No [ ]  If yes, please give details:       |

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| Any communication needs       |

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| **Hospital use only:** |
| Date referral received:       |
| Patient contacted:       |

It is important the relevant information sheet is given to the patient when they are referred under the 2ww priority.

The latest patient information sheets were updated in April 2010 in line with NICE guidance. To download the patient information sheets, please click on the link: <http://www.nottinghamchooseandbook.nhs.uk/index.php/county-two-week-wait/17-county-2ww-patient-information-sheets>

For queries on the appropriateness of this referral please contact Colorectal Nurse Practitioners 0115 924 9924 Ext. 62700.

Nottingham University Hospitals CircleNottingham

Two Week Wait Office Nottingham NHS Treatment Centre

Nottingham Cancer Centre Queen’s Medical Centre Campus

City Hospital Campus Lister Road

Hucknall Road Nottingham NG7 2FT

Nottingham NG5 1PB **T**: 0115 970 5800, extension 10011

**T:** 0115 840 5801 **F**: 0115 978 8765

**F:** 0115 840 5802 **Contact:** Joanne.fryer@circlenottingham.co.uk

**E:** TwoWeekWaitOffice@nuh.nhs.uk circlenottingham.co.uk

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