Suspected Cancer in Adults Urgent 2WW and Non Urgent BREAST

NHS Northern Cancer Alliance

URGENT ☐ **NON URGENT** ☐ **Date of referral:**

Name:		DOB:		NHS No:	

Attach this form to the e-referral within 24 hours

If the ERS not available, please send this form AND the 'Referral header sheet' by secure email or Fax

- ☐ The patient has been informed that this is an urgent referral for suspected cancer
- ☐ The patient is available and willing to attend hospital for tests/appointment within14 days
- ☐ The patient has been given the 2WW patient information leaflet

Hyperlinks to: NICE GUIDANCE Patient info leaflet including easy read

NICE Guidance

Refer people (male and female) **using a suspected cancer pathway referral (for an appointment within 2 weeks) for suspected breast cancer if they are:**

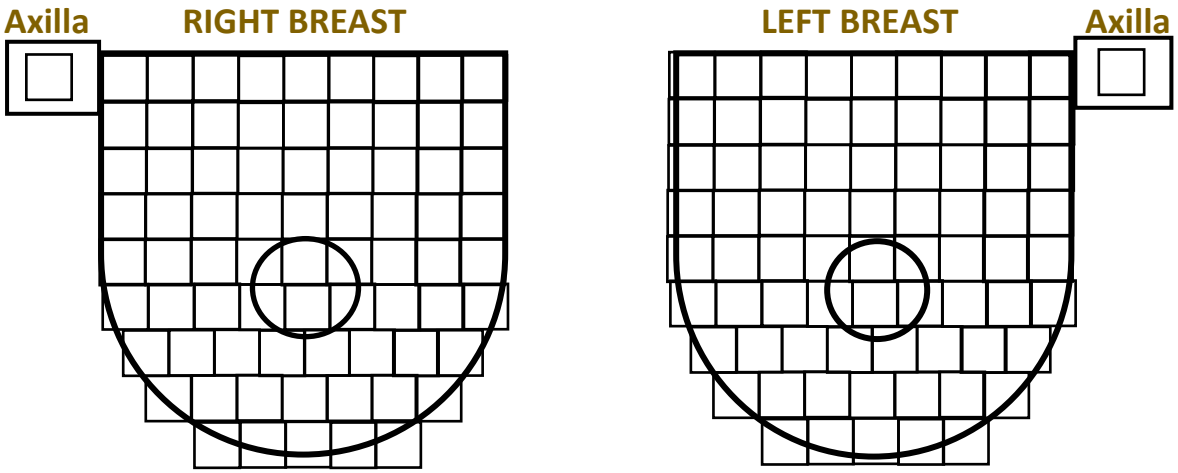
- ☐ Aged 30 years and over and have an unexplained breast lump with or without pain
- ☐ Aged 50 and over with any of the following symptoms in one nipple only:
  - ☐ Discharge ☐ Retraction ☐ Other changes of concern
- ☐ With skin changes that suggest breast cancer
- ☐ Aged 30 and over with an unexplained lump in the axilla

Consider non-urgent referral in people (male and female) **aged under 30 with an unexplained breast lump with or without pain**

Reason for referral – Compulsory

***If no information provided above, your referral will be returned**

Please indicate below where the specific problem is



Name:		DOB:		NHS No:	

Details of Last mammogram: Soft tissue X-ray breast...

The patient is pregnant	**YES** ☐	**NO** ☐	**Don't Know** ☐
The patient is prescribed Warfarin	**YES** ☐	**NO** ☐	**Don't Know** ☐
If yes, please ensure INR is checked the day before clinic			
The patient is prescribed NOAC	**YES** ☐	**NO** ☐	**Don't Know** ☐
The patient is prescribed Antiplatelets including Clopidogrel	**YES** ☐	**NO** ☐	**Don't Know** ☐

Date of last menstrual Period (if menstruating):			
The patient is prescribed HRT	**YES** ☐	**NO** ☐	**Don't Know** ☐
If yes, please give details:			
The patient is using contraception	**YES** ☐	**NO** ☐	**Don't Know** ☐
If yes, please give details:			
Family History of breast or ovarian cancer	**YES** ☐	**NO** ☐	**Don't Know** ☐
Please give details:			

Performance Status			
	☐	0	Fully active
	☐	1	Cannot carry out heavy physical work
	☐	2	Up and about more than half the day and can look after yourself
	☐	3	In bed or sitting in a chair for more than half the day and need help in looking after yourself
	☐	4	In bed or a chair all the time and need a lot of looking after

Please indicate COVID 19 risk:		
☐	**Standard**	No co-morbidities
☐	**Vulnerable**	Co-morbidities/frailty
☐	**Shielded**	In the shielded group because of high risk from COVID 19 infection

Investigation Results & any other relevant information

Has the patient had any imaging/pathology relevant at another hospital/independent sector organisation? ☐ **YES** ☐ **NO** **Please enclose results to avoid unnecessary delays**

If YES, please give date and name of organisation:

Name:		DOB:		NHS No:	

Referrer details

Name of referrer:		Date of Referral:	
Referring organisation Tel: Email: Fax:		**GP details** Tel: Fax:	
Name of GP to address correspondence to, if different to accountable GP			

Patient details

Name:		Address:	
Gender:			
DOB & Age	Age:		
NHS Number:			

Patient Contacts	Home:		Mobile:	
	Work:		Email:	
	Carer/Advocate: The patient has confirmed the following person should be included in correspondence – Name: Contact Details:			
Contact Consent	☐ Can leave message on answer machine ☐ Can contact by text ☐ Can contact by Email		NB: Not all services use Texts or Emails as a method of communication.	
Ethnicity:				
Interpreter:	☐ **Yes** Language:			
Accessibility Needs:	☐Wheelchair access ☐Deaf ☐Registered Blind ☐Learning Disability ☐Other disability needing consideration ☐Accompanied by Carer			
Risks:	☐Vulnerable Adult (detail below if any recording within last 3 years) Any other known risk:			
Other:				

Patient accessible information

Communication support: Uses a legal advocate...
Professional required: Interpreter needed - British Sign Language...
Contact method: Requires contact by telephone...
Information format: Requires information verbally...

If you have any problem with this form or suggested changes, please control & click here to open direct email.
(NB: NOT TO BE USED FOR REFERRING A PATIENT) 2WW NCA Breast Referral Form EMIS Web V4 updated Gateshead April 2018

To be completed by the Data Team (Insert Dates)
Received: / / **First Appointment booked:** / /
First Appointment date: / / **1st seen:** / /
Specify reason if not seen on 1st appointment:
Diagnosis: Malignant ☐ **Benign** ☐