

**Suspected Cancer in Adults
URGENT and Non-Urgent BREAST**

Date of referral **Short date letter merged**

Name:	Full Name	DOB:	Date of Birth	NHS No	NHS Number
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Attach this form to the e-referral within 24 hours

If the ERS not available, then send [this form AND 'Referral header sheet'](#) by secure [Email](#)

- Patient has been informed that this is an urgent referral for suspected cancer
- The patient is available and willing to attend for tests/appointment within 14 days
- The patient has been given the Fast track patient information leaflet

Hyperlinks to: [NICE GUIDANCE](#) [Patient info leaflet including easy read](#) [GP Breast Pain Pathway Information](#) [Breast Pain Patient Leaflet](#)

Symptomatic	Yes	Fast track Suspected Cancer	Yes
Cancer NOT suspected		Please use this section if your patient is LIKELY to have Breast Cancer	
Patients with breast pain alone (no palpable abnormality). I confirm prior recent primary care management as cancer extremely unlikely i.e 12 weeks regular NSAID or paracetamol as a minimum in line with NICE guidance NHS Breast Pain Info can be found here .	<input type="checkbox"/>	Aged 30 and over and have an unexplained breast lump with or without pain	<input type="checkbox"/>
People aged < 30 years with a lump	<input type="checkbox"/>	Aged 50 and over with any of the following symptoms in one nipple only: discharge retraction Other changes of concern	<input type="checkbox"/>
Asymmetrical nodularity/lumpiness or thickening (without discrete lump) that persists at review after menstruation	<input type="checkbox"/>		
Infection or inflammation that fails to respond to antibiotics	<input type="checkbox"/>	Skin changes that suggest breast cancer	<input type="checkbox"/>
Unilateral, eczematous skin of areola or nipple without other worrying signs such as lump, discharge, bleeding or ulceration. I confirm recent topical treatment (such as 0.1% mometasone) was applied for 2 weeks with no clinical response.	<input type="checkbox"/>	Aged 30 and over with an unexplained lump in the axilla.	<input type="checkbox"/>
Unilateral, spontaneous, non-bloody nipple discharge that is persistent or troublesome in people under 50yrs	<input type="checkbox"/>		

Reason for referral – Compulsory

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

Consultations

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Consultations

Please indicate below where the specific problem is

Axilla

RIGHT BREAST

LEFT BREAST

Axilla

Details of Last mammogram: **Single Code Entry: Mammogram...**

The patient is pregnant	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
The patient is prescribed Warfarin	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
<i>If yes, please ensure INR is checked the day before clinic</i>			
The patient is prescribed NOAC	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
The patient is prescribed Antiplatelets including Clopidogrel	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>

Date of last menstrual Period (if menstruating):			
The patient is prescribed HRT	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
<i>If yes, please give details:</i>			
The patient is using contraception	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
<i>If yes, please give details:</i>			
Family History of breast or ovarian cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Don't Know <input type="checkbox"/>
<i>Please give details:</i>			

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

Consent		
<input type="checkbox"/>	No problems anticipated	
<input type="checkbox"/>	There may be problems with consent. – e.g., significant dementia or learning disability clinical assessment may be needed before investigations	Include details here: <input type="text"/>
Disability		
<input type="checkbox"/>	No difficulty coping with investigation anticipated. No cognitive impairment/physical or behavioural issues that would make it difficult to manage the investigation	Straight to test investigations will be considered (expected to be able to move around and complete investigations)
<input type="checkbox"/>	There may be difficulties coping with investigation due to physical or mental disability Clinic first may be offered.	Include details here including known adjustments. <input type="text"/>

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:

Problems, Allergies, Acute / Repeat Medication

Problems

Allergies

Medication

Incomplete information may delay appropriate care for your patient

PLEASE COMPLETE THE REST OF THIS FORM

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Referrer details

Name of referrer:	Referring User <input type="text"/>	Date of referral:	Short date letter merged
Referring Organisation		GP details	
Organisation Name , Organisation Full Address (single line) Tel: Organisation Telephone Number Email: Organisation E-mail Address Fax: Organisation Fax Number		Usual GP Full Name Usual GP Organisation Name Usual GP Full Address (single line) Tel: Usual GP Phone Number Fax: Usual GP Fax Number	
Name of GP to address correspondence to, if different to accountable GP		<input type="text"/>	

Patient details

Name:	Full Name	Address:	Home Full Address (stacked)
Gender:	Gender(full)		
DOB & Age:	Date of Birth Age: Age		
NHS number:	NHS Number		
Patient Contacts:	Home:	Patient Home Telephone	Mobile: Patient Mobile Telephone
	Work:	Patient Work Telephone	Email: Patient E-mail Address
	Carer/Advocate: The patient has confirmed the following person should be included in correspondence – Name: <input type="text"/> Contact Details: <input type="text"/>		
Contact Consent:	<input type="checkbox"/> Can leave message on answer machine <input type="checkbox"/> Can contact by text <input type="checkbox"/> Can contact by Email	NB: Not all services use Texts or Emails as a method of communication.	
Ethnicity:	Ethnic Origin		
Interpreter:	<input type="checkbox"/> Yes Language: Single Code Entry: Main spoken language English... <input type="text"/>		
Accessibility Needs:	<input type="checkbox"/> Wheelchair access <input type="checkbox"/> Deaf Single Code Entry: Partial deafness... <input type="checkbox"/> Registered Blind Single Code Entry: Registered blind <input type="checkbox"/> Learning Disability, Single Code Entry: On learning disability register Single Code Entry: Moderate learning disability... Single Code Entry: Impairment with substantial and long term adverse effect on normal day to day activity (Equality Act 2010) Single Code Entry: Requires reasonable adjustment for health and care access (Equality Act 2010)... <input type="checkbox"/> Other disability needing consideration <input type="text"/> <input type="checkbox"/> Accompanied by Carer		
Risks:	<input type="checkbox"/> Vulnerable Adult (Details of any recording within last 3 yrs) Single Code Entry: Vulnerable adult Single Code Entry: No longer a vulnerable adult... Single Code Entry: Difficult intubation Other: <input type="text"/>		
Other:			
Single Code Entry: Military veteran Single Code Entry: Left military service Single Code Entry: History relating to military service Single Code Entry: History relating to Army service... Single Code Entry: Has a carer Single Code Entry: Is no longer a carer Single Code Entry: Is a carer			

Accessible information

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

If you have any problem with this form or suggested changes, please email contact-cdrc@healthinnovationenc.org.uk (NB: NOT TO BE USED FOR REFERRING A PATIENT) NCA Urgent and Non urgent Breast Fast track December 2025 CDRC Snomed EMIS Web. **This form has been developed by CDRC (Clinical Digital Resource Collaborative) – CDRC partners include NENC ICB, HI NENC, CBC Health Federation Ltd, NECS, Cumbria PRIMIS Informatics, and Derwentside Health Ltd. All intellectual property rights belong to the NENC ICB, this form cannot be copied or distributed by any other organisation.**

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