

# WMCA 2WW REFERRAL FORM FOR SUSPECTED COLORECTAL CANCER

<b>Patient Details:</b> <b>Surname:</b> Doe10 <b>Forename:</b> Jolly <b>DoB:</b> 01/01/1950 <b>Gender:</b> M <b>Ethnicity:</b> Caucasian <b>Address:</b>  <b>Hospital/NHS number:</b> G111110 <b>Landline number:</b> <b>Mobile number:</b> <b>Patient consents to be contacted by text on the above mobile?</b> Y <del>N</del> <b>Interpreter required?</b> <del>Y</del> N <b>First Language:</b> <b>Patient has capacity to consent?</b> Y <del>N</del>	<b>Registered GP Details:</b> <b>GP Saint Road</b>  <b>Fax no:</b> <b>Telephone:</b> <b>Email:</b> <b>Date of Decision to refer:</b> 15/02/2024 <b>Date of Referral:</b> 15/02/2024 <b>Name of referring GP:</b> Dr Good <b>GP Signature:</b>
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## GP Declaration

- They have symptoms which may be caused by cancer
- I have informed the patient:
- That they are being referred to the rapid access suspected cancer clinic
- The nature of the tests likely to take place
- I have provided the patient with a 2 week wait information leaflet

1	ANY ADULT (16 YEARS OR OVER) PLEASE REFER FOR FIT TEST THE SAME TIME AS THE REFERRAL DO NOT WAIT FOR FIT RESULT	Tick if present
a.	Abdominal mass	X
b.	Unexplained rectal mass	
c.	Anal ulceration/mass	

2	FIT POSITIVE PATHWAY Patients MUST be aged ≥ 40 years with a positive FIT (≥10 µg Hb/g) result and have one or more of the following:	Tick if present Must include the FIT value
a.	<b>Rectal bleeding</b> 2 or more episodes in a ≥ 4 week period	FIT result: ..... µg HB/g
b.	<b>Change in bowel habit</b> Looser/more frequent stools for ≥ 6 weeks	FIT result: ..... µg HB/g
c.	<b>Weight loss</b> Unexplained/Unintentional weight loss Either documented >5% loss in three months or with strong clinical suspicion	Amount ...10... kg Duration ...3...(weeks/months) O/E Weight ...60...kg O/E previous weight ...70...kg FIT result: .....120..... µg HB/g
d.	<b>Iron Deficiency Anaemia</b> in men (Hb <13g/L) or non-menstruating women (Hb <11.5g/L) Unexplained and un-investigated in the last 3 years	Hb....g/L MCV.....fL Ferritin..... µg/L FIT result: ..... µg HB/g

Commented [AB1]: Need to agree a date to review the form and pathway as ultimately the new FIT guidelines are for any adult, we have set the age cut off as >40yo now due to capacity issues only. This is not in alignment with the guidelines per say

Commented [AB2]: I have copied this from NSS as we need to get the wording identical between these pathways

Commented [AB3]: Taken from NSS pathway

3	<b>FIT NEGATIVE patients with Iron Deficiency Anaemia</b> In men or non-menstruating women aged ≥ 40 years with a negative FIT (<10 µg Hb/g) Unexplained and un-investigated in the last 3 years		<b>Tick if present</b> <b>Must include the</b> <b>FIT value</b>
	<p><b>All criteria must be fulfilled for a referral:</b> (Tick below)</p> <p><input type="checkbox"/> <b>Aged 40 years or over AND</b></p> <p><input type="checkbox"/> <b>FIT NEGATIVE (enter result .....µg HB/g) AND</b></p> <p><input type="checkbox"/> <b>Ferritin ≤45µg/L AND</b></p> <p><input type="checkbox"/> <b>ANAEMIA</b> (Hb &lt;13g/L in men or Hb &lt;11.5g/L in non-menstruating women)</p> <p>If meeting criteria, please ensure all the following:</p> <p><input type="checkbox"/> <b>Dipstick the urine.</b> (If positive consider referral on urology 2WW)</p> <p><input type="checkbox"/> <b>Screen for Coeliac disease.</b> (If positive refer to gastroenterology)</p> <p><input type="checkbox"/> <b>Renal function (urea, creatinine, eGFR)</b> (MUST be within 3 months)</p> <p><input type="checkbox"/> <b>You have commenced iron treatment</b> (Date commenced .....)</p>	<p>Hb .....g/dl</p> <p>MCV .....fL</p> <p>Ferritin .....µg/L</p> <p>TTG ...1..... U/ml</p> <p>Urea ...3.....mmol/L</p> <p>Creatinine...60....µmol/L</p> <p>eGFR ...90.....ml/min/1.73m<sup>2</sup>&gt;60</p>	<p>FIT result: ..... µg HB/g</p>
4	<b>For FIT NEGATIVE patients with ongoing NG12 symptoms/signs</b> Please refer to the FIT negative flow chart to review your options.		

**ENSURE UP TO DATE (WITHIN 3 MONTHS) BLOOD TESTS ARE AVAILABLE ON REFERRAL**

<b>ADDITIONAL HISTORY (or attach GP summary with the following details)</b>
<p>Last Consultation</p> <p>Weight loss and mass</p> <p>Medical Hx</p> <p>Nil</p> <p>Medications (inc anticoagulation &amp; antiplatelets)</p> <p>Nil</p> <p>Allergies</p> <p>Smoking status</p> <p>Alcohol intake</p> <p>Recent investigations</p>

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Including FBC, Ferritin, U&Es (within 3 months), AND Urine dipstick, TTG if FIT negative

## \* PLEASE COMPLETE FOR ALL REFERRALS:

\*WHO Performance status (see scale below, please tick one)      0 x    1 ☐    2 ☐    3 ☐    4 ☐

## WHO Performance Status Scale:

WHO Grade	Explanation of activity
0	Fully active, able to carry on all pre-disease 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 self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair

## For 2ww office use only

Date referral received	Triage date	Consultant
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