Use eRS for 2WW referrals

NHS

| BREAST UNIT REFERRAL FORM – FEMALE PATIENTS >16 years old ONLY | |
|---|---|
| Date of GP decision to refer: | No. of pages sent: |

**IF URGENT ADVICE FROM A CONSULTANT BREAST SURGEON WOULD BE HELPFUL FOR PATIENT MANAGEMENT AND/OR TO ASSESS NEED FOR REFERRAL, PLEASE USE ADVICE AND GUIDANCE VIA ERS**

| **INFORMATION PROVIDED TO PATIENT (To be provided by referring Clinician)** | Please **tick:** |
|---|---|
| Patient has been informed that cancer needs to be excluded | |
| Patient has been given written information leaflet regarding the cancer pathway | |
| Patient has confirmed they are available for the next 4 weeks (including weekends) | |

| **PATIENT DETAILS – Must provide current telephone number** | | | |
|---|---|---|---|
| Last name: | | First name: | |
| Gender: | | DOB: | |
| NHS No: | | | |
| Address: | | | |
| Tele (Day): | | Tele (Evening): | |
| Mobile No: | | Patient happy for a message to be left | |
| Email: | | | |

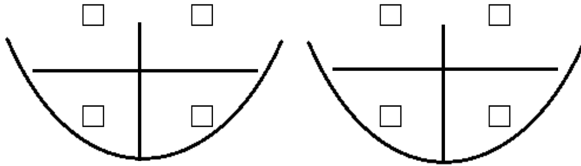
| **GP DETAILS** | |
|---|---|
| GP name: | |
| Practice Code: | |
| Address: | |
| Telephone: | |
| Practice email: | |

| | **PERFORMANCE STATUS** | select one |
|---|---|---|
| 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 light/sedentary work, e.g. house or office work. | |
| 2 | Ambulatory and capable of self-care, but unable to carry out work activities. Up and active 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. | |

**ADDITIONAL CONSIDERATIONS**

Please tick if the answer is yes to any of the questions below and give further information

| | | **If yes please give details:** |
|---|---|---|
| Transport required? | | |
| Language/Hearing difficulties? | | |
| Learning difficulties or potential impairment of capacity? | | |
| Mental capacity assessment required? | | |
| Known safeguarding concerns? | | |
| Mobility requirements (unable to climb on/off bed)? | | |

| PLEASE STATE PATIENT PRESENTING COMPLAINT |
|---|
| |
| **PLEASE DOCUMENT YOUR FINDINGS ON EXAMINATION** |
| **Right Breast** **Left Breast**  |
| **PLEASE STATE LIKELY DIAGNOSIS** |
| |

| PATIENT MEDICAL HISTORY | |
|---|---|
| **Relevant family history (breast or ovarian cancer)**<br>**Please note which relatives and age at diagnosis** | |
| **Existing conditions**<br>**(Please list or attach summary)** | |
| **Current medication/allergies**<br>**(Please list or attach a list)** | |

| REFERRAL TYPE | | |
|---|---|---|
| **PLEASE SELECT ONE OPTION:**<br>**SUSPECTED CANCER OR SYMPTOMATIC REFERRAL (CANCER NOT SUSPECTED)**<br>**PLEASE NOTE WE AIM TO SEE ALL BREAST REFERRALS WITHIN 2 WEEKS** | | **TICK ONE BOX BELOW** |
| **SUSPECTED CANCER** | **Please use for:**<br>• Patients aged ≥ 30 with an unexplained breast lump +/- pain<br>• Patients aged ≥ 50 with unilateral nipple discharge, retraction or other nipple changes of concern<br>**Please consider use for:**<br>• Patients with skin changes suggestive of breast cancer<br>• Patients aged ≥ 30 with an unexplained axillary lump | |
| **SYMPTOMATIC (CANCER NOT SUSPECTED)** | **Please use for:**<br>• Patients <30 with an unexplained breast lump +/- pain | |

- **PLEASE DO NOT REFER PATIENTS WITH BREAST PAIN ALONE (NO PALPABLE ABNORMALITY) WITHOUT A MINIMUM 4-6 WEEK TRIAL OF PRIMARY CARE MANAGEMENT, AS BREAST CANCER IS VERY UNLIKELY. Guidance on management of breast pain may be found here.**

**NONE OF THE ABOVE OR NEED MORE ADVICE BEFORE REFERRAL? PLEASE USE ADVICE AND GUIDANCE VIA ERS FOR URGENT ADVICE FROM A CONSULTANT BREAST SURGEON**