Use eRS for 2WW referrals

BREAST UNIT REFERRAL FORM – MALE PATIENTS ONLY	
Date of GP decision to refer:	No. of pages sent:

NOTE: This form is NOT for use for patients under 16

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

Transport required?		**If yes please give details:**
Language/Hearing difficulties?		
Learning difficulties?		
Mental capacity assessment required?		
Known safeguarding concerns?		

Mobility requirements (unable to climb on/off bed)?		

BACKGROUND INFORMATION/RISK FACTORS			
BMI		Smoker/ex-smoker	
Alcohol		Other please specify	

REFERRAL TYPE		
PLEASE SELECT ONE OPTION: **SUSPECTED CANCER OR SYMPTOMATIC REFERRAL (CANCER NOT SUSPECTED)** **PLEASE NOTE WE AIM TO SEE ALL BREAST REFERRALS WITHIN 2 WEEKS**		**TICK ONE BOX BELOW**
SUSPECTED CANCER **Please use for patients with:**	• A discrete, hard lump ± fixation, ± skin tethering	
	• Spontaneous unilateral bloody nipple discharge	
	• Nipple retraction/distortion or suspicious skin changes	
SYMPTOMATIC (CANCER NOT SUSPECTED) **Please use for patients with:**	• Gynaecomastia with **no obvious physiological or drug cause (including anabolic steroids, propecia/ finasteride and cannabis use).** Consider primary care management – see https://patient.info/doctor/gynaecomastia	
	• Unexplained lump in axilla	
	• Unilateral eczematous change of the skin of areola or nipple (please try topical mild steroid for 2 weeks prior to referral)	
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		

ESSENTIAL PRE-REFERRAL INVESTIGATIONS

Any male patient with a breast lump and/or tenderness **MUST** have the following bloods completed, reviewed and results attached. Do see and consider guidance for primary care management of gynaecomastia before referral: https://patient.info/doctor/gynaecomastia

LFTs		Oestradiol		LH		FSH		TSH		Prolactin	
AFP		HCG		LDH		U&Es		Testosterone			

FURTHER CLINICAL INFORMATION (or attach letter/paste consultation record)

PATIENT MEDICAL HISTORY

Relevant family history (breast or ovarian cancer) **Please note which relatives and age at diagnosis**	
Existing conditions **(Please list or attach summary)**	
Current medications/allergies **(Please list here or attach a list)**	