LUNG SUSPECTED CANCER REFERRAL FORM	
Date of GP decision to refer:	No. of pages sent:

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

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 understands that they may go straight to a diagnostic test at the hospital	
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:	

	WHO 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	
Relevant family history			

LUNG SUSPECTED CANCER
REASON FOR REFERRAL (Please see algorithm on page 3)

PLEASE INDICATE CHEST X-RAY FINDING **Mandatory CXR to have been done in the last 4 weeks**
☐ Pleural effusion (please make an urgent referral to the chest clinic pleural service for patients attending Ipswich Hospital)
☐ Normal
☐ Suspicious (incl slowly resolving consolidation)

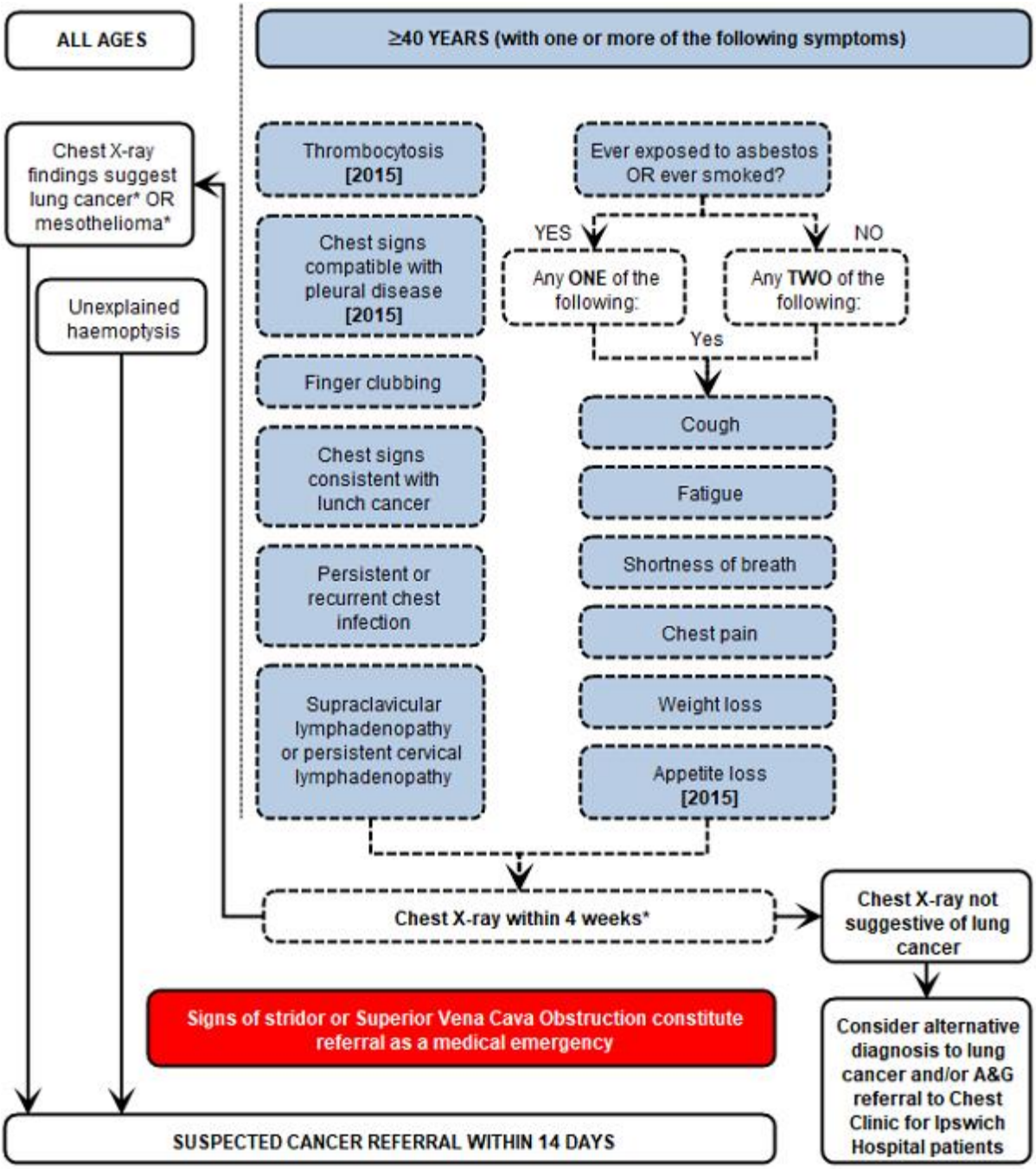
INVESTIGATIONS (Mandatory)

It is mandatory to do all the following blood tests before referral; please tick the box to confirm they have been done.

FBC LFT U+E Clotting Glucose CRP eGFR Creatinine Bone Profile ☐

ADDITIONAL INFORMATION (Please attach any additional information if deemed relevant)

PATIENT MEDICAL HISTORY	
Existing conditions (please list or attach summary)	
Smoking status	Current smoker…….Yes ☐ Ex smoker……..Yes ☐ Never smoked……..Yes ☐ Pack year history: _____ Unknown ☐
Spirometry results (please attach)	
Current medications	Anticoagulants/ Antiplatelets……..Yes ☐ Immunosuppressants……..Yes ☐ Attach list and indications for all current medications:
Allergies	Yes ☐ If yes, please list below:
Other medical conditions	Diabetic…….Yes ☐ Please state any other medical conditions:



* The majority of chest X-rays will be abnormal but a normal chest X-ray does not exclude diagnosis of lung cancer. In a 2006 BJGP study of chest X-rays in lung cancer patients, 23% had a negative X-ray. (Macmillan Rapid Referral Guidelines, July 2015) Therefore, if your patient does not meet NICE suspected cancer referral criteria, but you feel they warrent further investigation, please disclose full details in your referral letter.