South Yorkshire and Bassetlaw Integrated Care System
CANCER ALLIANCE
Working with Derbyshire

Lung

Fast Track Referral – 2 Week Wait

Please refer via the e-Referral Service

Patient Details:

Patient Name			
Address			
DOB		**NHS No.**	
Home Tel. No.		**Gender**	
Mobile Tel. No.		**Ethnicity**	
Preferred Tel. No.		**Email Address**	
Main Spoken Language		**Interpreter needed?**	
Transport needed?		**Patient agrees to telephone message being left?**	
Communication requirements	Hard of hearing: ☐ Visually impaired: ☐ Learning/mental difficulties: ☐		
Date of Decision to Refer			

Registered GP Details:

Practice Name			
Registered GP		**Usual GP / Referring GP**	
Registered GP Address			
Tel No.		**Fax No.**	
Email		**Practice Code**	

Please use separate children's proforma for patients under 16

The criteria are compliant with 2015 NICE guidelines for referring those with suspected cancer and not a substitute for your own clinical judgement or taking specialist professional advice as appropriate.

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL

Has the patient been advised that this referral is to exclude a cancer diagnosis and has a 2WW patient referral letter been given?
Yes ☐ **No** ☐

Is the patient available for their appointment in the next 2 weeks so they understand how important it is to let the practice know ASAP if they cannot attend?
Yes ☐ **No** ☐

WHO performance status: (please tick)

0 –Able to carry out all normal activity without restriction ☐
1 –Restricted in physically strenuous activity, but able to walk and do light work ☐
2 –Able to walk & capable of all self-care, but unable to carry out any work. Up and about 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 on any self-care. Totally confined to bed or chair. ☐

Never Smoked? ☐	**Smoker?** ☐	**Ex-smoker?** ☐
Smoking cessation education offered?		**Yes** ☐ **No** ☐ **N/A** ☐

Refer to 2WW Lung Service if suspicion of cancer (men & women):	Tick if criteria applies
• CXR suggests possible cancer	☐
• 40 or over with unexplained haemoptysis (Please arrange CXR at time of referral)	☐
• Normal CXR but significant on-going clinical concerns	☐
• Underlying chronic respiratory problems – unexplained changes in existing symptoms	☐

Order urgent CXR (within 2 weeks) if:	Tick if criteria applies
40 or over, never smoked, but 2 or more of the following or	☐
40 or over and previously smoked, with 1 or more of the following or	☐
Any age with asbestos exposure and 1 or more of the following:	☐
• Cough	☐
• Fatigue	☐

• Shortness of breath	☐
• Chest pain	☐
• Weight loss	☐
• Appetite loss	☐

Consider urgent CXR (within 2 weeks) if your patient has:	Tick if criteria applies
Persistent or recurrent chest infection	☐
Finger clubbing	☐
Supraclavicular lymphadenopathy or persistent cervical lymphadenopathy	☐
Thrombocytosis	☐
If chest signs compatible with pleural disease	☐

NB: UP TO DATE U&E REQUIRED TO ENABLE CT SCAN WITH CONTRAST

Investigations required for referral within the last month: (but do not delay referral)	Tick if criteria applies
• U&E	☐

Is the Patient currently on any Anticoagulants (Y/N) (If Yes State which):

Is the Patient currently on any Antiplatelet Medications (Y/N) (If Yes State which):

Current Medications <Medication>

Known Allergies <Allergies & Sensitivities>

Prior History of Malignancy / Past Medical History

Presenting Symptoms and Examination findings / Other information