Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Rapid Diagnostic Centre

Rapid Diagnostic Cancer Clinic (RDCC) for Vague Symptoms suggestive of cancer

Please complete the following details and send this form via e-RS; under the 2WW subfolder

We advise using C the Signs to ensure correct use of the pathway

the signs

Our team are happy to answer any queries prior to referral by email or phone:
Email: stgh-tr.rdcc@nhs.net
Phone: 020 8725 4221 or 07823734383

Tick each box to confirm that your patients meet referral criteria:

☐ Likely diffuse cancer on radiology & cannot wait for 2 weeks for TWR appointment due to symptoms e.g. pain/ nausea/ vomiting

☐ Incidental finding of disseminated malignancy of no clear origin

☐ Bony lesion(s) of likely malignant origin (in the absence of a clear primary)

☐ Unintentional/unexplained weight loss (greater than 5% recorded weight or clearly reported by patient/carer) – Please provide

Baseline weight ☐

- Amount of weight loss ☐
- Duration of weight loss ☐

☐ Non-specific abdominal symptoms of more than four weeks duration Does not meet referral criteria for alternative tumour-specific pathways

☐ Significant GP clinical suspicion of possible cancer diagnosis where there is no clear urgent referral pathway

Please confirm that the patient is :

☐ Over the age of 18

☐ Well enough to attend Outpatient Clinics

☐ Aware they may have cancer

☐ Available to be seen in the next 2 weeks

☐ Has a telephone number that accepts No Caller ID calls

We cannot accept patients that do not meet these criteria

Upon referral, please ensure your patient has a copy of the patient information leaflet:

https://www.stgeorges.nhs.uk/gps-and-clinicians/patient-information-leaflets-clinician-resource-v2/

Referral date:		
Patient Details		
Surname:	First name:	Title:
Gender:	Are they transgender:	Sexuality:
DOB:	Age:	NHS No.:
Ethnicity:	Language:	
Patient address:		Postcode:
Telephone number:		Email:
Transport required ☐		
Is an interpreter required ?– if yes please specify language		
Carer/Key Worker Details		
Name:	Contact:	Relationship to Patient:
Cognitive, Sensory or Mobility impairment		
Cognitive ☐	Sensory ☐	Mobility ☐
State safeguarding concerns:		

We must have the **practice bypass number** and **email address** that are **checked regularly** as we may need to contact you for further information.

GP Details	
Practice Bypass Number:	Email:
Usual GP Name:	
Practice Name:	Practice Code:
Telephone number:	
Referring Clinician:	

Reason for Referral

Enter clinical description, including history and examination, outlining the reason for referral to RDCC:

List the symptoms at presentation and date of first presentation of symptoms:

State the number of consultations for cancer-related symptoms up to one year before referral (telephone of face-to-face in any clinical setting)

Have you referred this patient to secondary care for the same condition?

If so – please attach outcome letter and relevant scans/results:

ECOG Performance Status

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 housework, office work. ☐

2 Ambulatory and capable of all self-care but unable to carry out any work activities. ☐

The patient is 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. The patient is totally confined to bed or chair. ☐

Investigations, blood tests and imaging results.

Include results of all relevant investigations including imaging.

If results are pending provide information including type of investigation and the Trust performing the tests.

FBC , FE BINDING STUDIES,	U&E with eGFR
LFTS including globulins	CRP & ESR

BONE profile	HBA1C
TFTS	CLOTTING
Appropriate tumour markers: CA125 (if clinically indicated), PSA (if clinically indicated)	
Serum protein electrophoresis (if clinically indicated)	
Urinary Bence Jones Protein (if clinically indicated)	
Quantitative Faecal Immunochemical Test (FIT) – **PLEASE NOTE THIS TEST IS NOT AVAILABLE IN SECONDARY CARE**	
Chest Xray (preferable)	

Check that above results have been auto-populated at completion of this referral.

Additional clinical information:

Personal/relevant patient information:

Past history of cancer:

Relevant family history of cancer:

Is there any history of mental health which may impact upon patient engagement? Y/N

Do you think the patient would benefit from a review by Cancer Psychological Support Service (can help with engagement with investigations and support during diagnostic process)? Y/N

If yes please give details