University Hospital of North Staffordshire NHS Trust

14 DAY WAIT – URGENT REFERRAL

COLORECTAL

GENERAL ENQUIRIES : Tel 01782 554088

CLINICAL ENQUIRIES : Colorectal Cancer Team Tel 01782 552380

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

PATIENT DETAILS	**GP DETAILS**
Name: Address: NHS Number: Hospital Unit No: Date of Birth: Sex: **M / F** Interpreter required: **Y / N** Language: _____ Sign Language required: **Y / N** **Contact Phone No** for next 48hrs – **Home:** **Work:** **Mobile:**	Name: Phone No: Fax No: GP Signature: **Decision to refer date:**

REASON FOR REFERRAL *(please indicate as appropriate)*

Rectal bleeding and change of bowel habit of ≥ 6 weeks duration (aged 40 and over)	☐
Rectal bleeding without change of bowel habit with no obvious cause ≥ 6 weeks duration (over 60 years old)	☐
Change of bowel habit to looser/more frequent stools persisting for 6 weeks or more without bleeding (aged 60 years and over)	☐
Abdominal mass thought to be large bowel cancer (any age)	☐
Palpable rectal mass (intraluminal) (any age)	☐
Males of any age with Hb ≤ 11g/100ml; MCV≤ 79fL iron deficiency picture Hb …. MCV ……	☐
Non menstruating female with Hb ≤ 10g/100ml; MCV≤ 79fL iron deficiency picture Hb ….. MCV ……	☐

I have performed a digital rectal examination: Y / N

Please state findings:

If a rectal examination has not been possible please explain why:

Any other relevant symptoms not covered by the guidelines

I confirm that I have discussed the possibility with the patient that the diagnosis may be cancer ☐

Have you ensured that the patient is available for OPA over the next 14 days? ☐

When completed please FAX to Central Referral Bureau on 01782 555343 within 24 hours