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| **NWAngliaFT RAPID DIAGNOSTIC SERVICE (RDS+) REFERRAL FORM**Date of decision to refer: Date Referral received: No. of pages sent:  |

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

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| **INFORMATION PROVIDED TO PATIENT (To be provided by referring Clinician) please complete:** |
| Has the patient had a test that suggests Cancer is likely?  | **Please give details:**  |
| Has the patient been informed that Cancer is likely? **Please ensure they are aware.** | Y/N |
| Does the patient fit on an existing 2 week wait pathway? **Only continue with this referral if the answer is NO, thank you.** | Y/N |
| Has the patient been given written information regarding the diagnostic (RDS+ pathway)? | Y/N |
| Is the patient aware that they **may** go straight to diagnostic tests after being ‘virtually triaged’ by the RDS+ team, before being seen? | Y/N |
| Has the patient confirmed they can be available for tests as required?  | Y/N  |

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| **PATIENT DETAILS** – **Must provide current telephone number** |
| Last name: |   | First name: | Email: |
| Gender:  |  | DOB:  | NOK Contact:  |
| NHS No:  |  |
| Address: |  |
| Tele (Day):  |  | Tele (Evening): |
| Mobile No:  |  | Patient happy for a message to be left  | Y/N |
| **GP DETAILS** |
| GP name: | Import GP details from EMIS/System 1  |
| Practice Code:  |  |
| Address:  |  |
| Telephone: |  |
| Practice email: |  |
|  **RDS+ INCLUSION CRITERIA – REASON FOR REFERRAL**  |
| 1. Symptoms which may represent malignant disease but **DO NOT FIT existing 2WW pathway** (NICE NG12).
 | Y/N |
| 1. Investigations undertaken in the community suggestive of **CANCER OF UNKNOWN PRIMARY (CUP)**
 | Y/N |
| 1. Unexplained persistent non – tender lymphadenopathy (consider Breast and H&N pathways first)
 | Y/N |
|  **EXCLUSIONS – ALREADY UNDER INVESTIGATION/REFERRAL TO SUSPECTED CANCER PATHWAY** | Y/N |

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| **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 outLight / 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. | [ ]  |

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|  **Clinical Frailty Score:**  |
| Please tick a score of frailty –as per the descriptors below: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 – **Very Fit:** People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age. 2. **Well:** People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally. 3. **Managing well:** People whose medical problems are well controlled, but are not regularly active beyond routine walking. 4. **Vulnerable:** While not dependent on others for daily help, often symptoms limit activities. A common complaint is being ‘slowed up’ and/or being tired during the day. 5. **Mildly frail:** These people often have more evident slowing, and need help in high order ADL’s. Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework. 6. **Moderately frail**: People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and bathing and might need minimal assistance with dressing. 7. **Severely Frail:** Completely dependent for personal care, from whatever cause (physical or cognitive). Not at risk of dying within 6 months. 8. **Very severely Frail:** Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness. 9. **Terminally ill:** Approaching the end of life. This category applies to people with a life expectancy <6 months. **Scoring frailty in people with Dementia:** The degree of frailty corresponds to the degree of dementia. **Mild dementia**: Forgetting details of recent events, repeating the same question/story and social withdrawal. **Moderate dementia:** Recent memory very impaired, can recall some past life events well. Personal care with prompting. **Severe dementia:** Cannot do personal care without help.  |

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| **ADDITIONAL CONSIDERATIONS**If yes to any of the below – please give details:  |
| Transport required? | **Y/N** | **Detail any relevant information:** |
| Language/Hearing difficulties? | **Y/N** |
| Learning difficulties? | **Y/N** |
| Mental capacity concerns? – please detail in box (LPA etc) | **Y/N** |
| Known safeguarding concerns? As above |  |
| Mobility requirements (unable to climb on/off bed)? |  |
|  **BACKGROUND INFORMATION/RISK FACTORS – please give details** |
| BMI | Smoker/ex-smoker |
| Alcohol | Interpreter required |
| Relevant family history | Other please specify: |

**Clinical Triage is a crucial element of assessment so please give as much information in the following section to ensure a smooth pathway and ensure ALL pre-referral tests are requested.**

**REFERRALS THAT ARE INCOMPLETE, LACKING INFORMATION OR NO ABNORMALITY DETECTED WILL BE REJECTED.**

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| **ESSENTIAL FILTER TESTS AND INVESTIGATIONS** |
| It is mandatory to undertake appropriate blood tests before referral, please tick the box to confirm they have been done, where being referred into the service. [ ]  Some patients will be picked at point of abnormal test being triaged by RDS+ team – they will then arrange filtering tests as part of staging work up. |
| FBC and clotting  | **Y/N** | ESR/CRP | **Y/N** |
| U&E’s/eGFR/LFT’s  | **Y/N** | TFT’s, Glucose, HBA1c if diabetic | **Y/N** |
| CXR - if clinically indicated | **Y/N** | Bone profile | **Y/N** |

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| **CLINICAL INFORMATION (OR ATTACH LETTER)** |
| **This referral will be triaged as part of the RDS triage service. Please provide a full clinical history and results of recent tests, as this will help triage and plan further investigations in a timely and effective manner.**PATIENT MEDICAL HISTORY**:** Existing conditions (please list or attach summary) Current medication (please list or attach list with indications) Allergies: Anticoagulants/ Antiplatelets Immunosuppressants Please give details:Any additional tests taken, not listed above, of relevance: |