

BREAST SUSPECTED CANCER REFERRAL FORM or Symptomatic without Suspicion

Date of GP decision to refer: [Click here to enter a date.](#)

No. of pages sent:

IF NHS E-REFERRAL IS UNAVAILABLE, COMPLETE FORM AND EMAIL TO THE REFERRAL TEAM WITHIN 24 HOURS.

PATIENT DETAILS – <u>Must</u> provide current telephone number	GP DETAILS
Last name: _____ First name: _____ Gender: _____ DOB: _____ NHS No: _____ Address: _____ Telephone (Day): _____ Telephone (Evening): _____ Ethnicity : _____ Patient agrees to telephone message being left? Y <input type="checkbox"/> N <input type="checkbox"/> Transport required? Y <input type="checkbox"/> N <input type="checkbox"/> Email: Y <input type="checkbox"/> N <input type="checkbox"/> Interpreter required? Y <input type="checkbox"/> Language/Hearing: _____ Learning difficulties? Y <input type="checkbox"/> Reduced mental capacity? Y <input type="checkbox"/> Known safeguarding concerns? Y <input type="checkbox"/> Mobility requirements (unable climb on/off bed)? Y <input type="checkbox"/>	GP name: _____ Practice Code: _____ Address: _____ Tel: _____ Fax: _____ Practice email: _____
	CLINICAL INFORMATION
	Please ensure the following blood results are available FBC Y <input type="checkbox"/> Allergies Y <input type="checkbox"/> Anticoagulants Y <input type="checkbox"/> HRT /Contraception Y <input type="checkbox"/> Pregnant or breastfeeding? Y <input type="checkbox"/>
	PATIENT MEDICAL HISTORY
	PMH of breast disease Y <input type="checkbox"/> Dates and where seen: _____ Existing conditions & Risk factors(inc smoking status & BMI): _____
	Level of Concern Pretty sure my patient has cancer <input type="checkbox"/> Unsure, it might well be cancer <input type="checkbox"/> Don't think my patient has cancer but want or rule it out <input type="checkbox"/> Doesn't meet criteria but I am concerned <input type="checkbox"/>
*WHO Performance Status	
0 Fully active 1 Able to carry out light work 2 Up and about 50% of waking time 3 Limited self-care, confined to bed/chair 50% 4 No self-care, confined to bed/chair 100%	
WHO Patient Performance status (see key*) Please tick <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL			
Cancer needs to be excluded	Y <input type="checkbox"/>		
Patient given referral information leaflet	Y <input type="checkbox"/>		
Date(s) unavailable next 14 days:			
2ww Suspected Cancer	Yes	Symptomatic	Yes
Please only use this section if you feel this patient is LIKELY to have Breast Cancer		cancer NOT suspected	
Discrete, hard lump ± fixation, ± skin tethering	<input type="checkbox"/>	Women aged < 30 years with a lump	<input type="checkbox"/>
30 years and older with a discrete lump that persists post period / menopause	<input type="checkbox"/>	Patients with breast pain alone (no palpable abnormality) Please don't refer until tried primary care management as cancer extremely unlikely (4-6 weeks regular NSAID or paracetamol as a minimum – see best practice guidance) https://www.breastcancercare.org.uk/publications/benign-breast-conditions/breast-pain-bcc71	<input type="checkbox"/>
50 years and older with spontaneous unilateral bloody or blood stained nipple discharge or which stains clothes	<input type="checkbox"/>	Asymmetrical nodularity or thickening that persists at review after menstruation or recurrent cyst	<input type="checkbox"/>
50 years and older with unilateral nipple retraction or distortion of recent onset (<3 months onset)	<input type="checkbox"/>	Infection or inflammation that fails to respond to antibiotics	<input type="checkbox"/>
Skin distortion / tethering / ulceration / Peau d'orange/other changes of concern	<input type="checkbox"/>	With unilateral eczematous skin of areola or nipple : please don't refer until tried topical treatment such as 0.1% mometasone for 2 weeks	<input type="checkbox"/>
Unexplained lump in axilla < 30 years	<input type="checkbox"/>	Persistent unilateral nipple discharge' (not related to breast feeding/pregnancy)	<input type="checkbox"/>

If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter

Please attach a Patient summary including:

- Referral letter (if applicable) Investigation results PMH Up-to date medications list and allergies

Clinical History and Examination

Clinical History and Examination

Family History *(please specify)* :

Relevant Imaging	Location
	Date

Males age 50 and over with unilateral firm sub areolar mass with or without nipple distortion and skin changes – see Male GWH Urgent GP referral proformas.

TVCA	Great Western Hospital	Emergencies only :	
	Refer via e-RS	gwh.2ww@nhs.net	

For hospital to complete

UBRN:

Received date: