**Rapid Access Diagnostic Clinic (GSTT)**

**REFERRAL DATE:** 

**Please email or send e-referral within 24 hours.**

**Fax is no longer supported due to patient safety and confidentiality risks**

[**gst-tr.rapidaccessdiagnosticclinic@nhs.net**](mailto:gst-tr.rapidaccessdiagnosticclinic@nhs.net)

**If you would like to discuss a clinical case prior to referral please contact the team on 02071887188 Ext: 55667 or 07393763157**

**PATIENT DETAILS**

**SURNAME:**       **FIRST NAME:**       **TITLE:** 

**GENDER:**       **DOB:**        **AGE:****NHS NO:** 

**ETHNICITY:**        **LANGUAGE:** 

**INTERPRETER REQUIRED**  **TRANSPORT REQUIRED**

**PATIENT ADDRESS:**       **POSTCODE:** 

**DAYTIME CONTACT**🕾**:** 

**HOME**🕾**:**       **MOBILE**🕾**:**       **WORK**🕾**:** 

**EMAIL:** 

**CARER/KEY WORKER DETAILS**

**NAME:**       **CONTACT**🕾**:**       **RELATIONSHIP TO PATIENT:** 

**COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT**

**COGNITIVE**   **SENSORY**  **MOBILITY**   **DISABLED ACCESS REQUIRED**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**SAFEGUARDING**

**SAFEGUARDING CONCERNS**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**GP DETAILS**

**USUAL GP NAME:** 

**PRACTICE NAME:**       **PRACTICE CODE:**  

**PRACTICE ADDRESS:** 

**BYPASS**🕾**:** 

**MAIN**🕾**:**       **FAX:**       **EMAIL:** 

**REFERRING CLINICIAN:** 

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Criteria**   |  | | --- | | Patients aged 40 years or over with one or more of the following **unexplained** symptoms may be referred to the Rapid Access Diagnostic Clinic: | | * General malaise/fatigue | | * Unintentional weight loss (greater than 5% recorded weight or clearly reported by patient/carer) | | * Non-specific abdominal symptoms of more than four weeks duration (which do not fit into an established urgent suspected cancer referral pathway) | | * New onset or unexplained worsening of breathlessness (please take steps to rule out undiagnosed heart failure, IHD, thrombo-embolic disease, COPD and infection – but note that previously diagnosed IHD/heart failure/COPD do not preclude referral) | | * Persistently abnormal laboratory tests (tested on at least 2 occasions) which are not readily explicable including: * Significantly elevated alkaline phosphatase (more than twice the upper limit of normal) * Raised CRP (or ESR/plasma viscosity) * Increased calcium | | * Unexplained worsening of pain (especially back pain) | | * Significant GP concern regarding a possible cancer diagnosis where there is no clear urgent referral pathway (for example, unexplained DVT, paraneoplastic syndromes, etc). Please describe the clinical picture and the reason for your concern in the text box additional clinical information   Patients with abdominal symptoms and/or weight loss may also require:   * Coeliac antibodies, serum amylase, gamma GT * CA125 and urgent pelvic ultrasound scan (where this is available in a timely way) - in women over 45 years * Abdominal ultrasound scan (if appropriate to do before referral please ensure requested urgently and the result is included with the referral) * Thrombocytopenia | |

Please Note: A number of symptoms indicate a specific cancer diagnosis (for example cough, abnormal vaginal bleeding, change in bowel habit, dysphagia, and haematuria). Any patients meeting the urgent suspected cancer referral guidelines for any tumour site should be referred using the appropriate 2WW urgent suspected cancer referral pathway and referral forms. 

**Additional clinical information:**

**Personal/relevant patient information:**

**Past history of cancer:**

**Relevant family history of cancer:**

**ALLERGIES**

**MEDICATION**

**INVESTIGATIONS**

**Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.**

**Required Investigations:**

**CHEST X RAY AND ULTRASOUND SCAN IF** APPROPRIATE

**URINANALYSIS**

**FULL BLOOD COUNT**

**RENAL FUNCTION**

**BONE PROFILE**

**LIVER FUNCTION**

**HBA1c**

**THYROID FUNCTION**

**ROUTINE AUTOMATIC TABULATED DATA**

**CRP**

**HIV test**

**CA 125**

**To help us with evaluation of the service please provide us with information below if possible:**

**First presentation to GP:**

**Date:**

**How many appointments prior to referral patient had in Primary care: OFFICE USE ONLY**