**South East London Accountable Cancer Network – GSTT EBUS Referral Form**

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| **PLEASE NOTE ALL FIELDS ARE MANDATORY. REFERRAL FORMS WILL ONLY BE ACCEPTED IF FULLY COMPLETED.** |

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| **REFERRING ORGANISATION DETAILS** | |
| **Referring Clinician:** | **Referring Clinician email address (required for results):** |
| **Referring organisation name:**  KCH (DH)  / PRUH  / UHL  / QEH | **Date of referral:** / / |
| **Name of person completing form:** | **Referrer contact telephone:** |

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| **PATIENT DETAILS** | | | | | | | |
| **Patient Name**: | | | **Date of Birth**: / / | | | **Sex**:  Male  Female | |
| **NHS Number**: | | | **Local Patient Identifier**: | | | | |
| **Patient Contact Telephone Numbers** (give all available):   * Home/Work: * Mobile: | | | **Correspondence address**: | | | | |
| **Patient E-mail**: | | | **Patient GP Details**: | | | | |
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| **PATHWAY DETAILS** | | | | | | | |
| **Pathway Type:**  62 DAY  OTHER | | **2ww Referral Date:** / / | | **62 day Breach Date:** / / | | | |
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| **CLINICAL DETAILS** | | | | | | | |
| **EBUS Referral Indication (Please tick one box):** | | | | | | | **✓** |
| **Note: It is not usual practice to perform EBUS in patients with a WHO PS of 3, or where there is no plan to offer radical treatment or palliative chemotherapy** | 1. Staging known lung cancer | | | | | |  |
| 2a. Diagnosis suspected lung cancer | | | | | |  |
| 2b. Tissue for molecular testing | | | | | |  |
| 3. Suspected cancer recurrence – please specify: | | | | | |  |
| 4. Suspected granulomatous disease (sarcoid, TB) | | | | | |  |
| 5. Other – please specify: | | | | | |  |
|  | | | | | | | |
| **Minimum Clinical Dataset:** | | | | | | | |
| **Clinical History (including co-morbidities):** | | | | | | | |
| **Anti-coagulation**: YES  NO  If **YES**, please specify which medication: | | | **INR Result:**  (test within 2 weeks of ref) | | **Platelet Count:** | | |
| **Performance status (0-4)**: | | | **Treatment intent:** Curative  Palliative | | | | |
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| **Scans Performed (Please note, referrals will NOT be accepted if scans have not been sent/IEP’d):** | | | | | | | |
| **CT SCAN** (must be within 6 weeks of referral) | | | **Scan Date**: | | **Imaging Sent/IEP’d?** | | |
| **PET-CT SCAN** (must be with 1 month of referral) | | | **Scan Date**: | | **Imaging Sent/IEP’d?** | | |
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| **PLEASE EMAIL COMPLETED FORMS TO:** [**gst-tr.ebusgstt@nhs.net**](mailto:gst-tr.ebusgstt@nhs.net) | | | | | | | |

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| **EBUS TEAM: Please copy results/reports to relevant Trust email below, copying in Referring Clinician** | | | |
| **KCH – PRUH:** | cancermdm.bromley@nhs.net | **LGT – QEH:** | LG.CWT-Lung@nhs.net |
| **KCH – DH:** | [kch-tr.CancerData@nhs.net](mailto:kch-tr.CancerData@nhs.net) | **LGT – UHL:** | LG.CWT-LungUHL@nhs.net |