**CANCER RISK ASSESSMENT REFERRAL FORM**

Please use this form to refer women and men with a **family history of bowel, ovarian or endometrial cancer** to the Bowel Cancer Risk Assessment Service for family history assessment and organisation of appropriate screening/genetics referral, provided that:

* The patient is currently **asymptomatic** (symptomatic patients should be referred to the symptomatic bowel service)
* We will accept any referral from a G.P. but are currently not in a position to accept self-referrals

Refer to: **Guy’s Bowel Cancer Risk Assessment Service**

**7th Floor, Borough Wing**

**Guy’s Hospital Email:**

**Great Maze Pond gst-tr.cancerriskassessment@nhs.net**

**London, SE1 9RT**

Date:

Interpreter required: (specify language)

* Yes
* No

Reason for referral: (i.e. details of family history, ages of diagnosis of relatives with cancer, relationship of affected relative(s) to patient, type of cancer etc. (Continue overleaf if necessary)

* Bowel cancer
* Ovarian cancer
* Endometrial cancer

Has patient had a colonoscopy or previous cancer investigations or treatment? If so, when, where and what was the outcome?

Patient name: Referring clinician:

 GP surgery address:

Address:

Telephone number: Postcode:

DOB:

NHS no. Telephone:

Hospital no.