**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:       | [ ]  |
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| **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** |

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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 | **LGT – UHL:** | LG.CWT-LungUHL@nhs.net |