**WIRRAL BREAST SERVICE REFERRAL FORM**

**This form has two parts for clinical information, it is essential to complete the correct part.**

|  |  |
| --- | --- |
| **2 WW URGENT****SUSPECTED CANCER** | **SYMPTOMATIC** **CANCER NOT SUSPECTED** |

# Additional guidance links

Breast pain information – <https://www.wuth.nhs.uk/media/16210/breast-pain-information-for-gps-2.pdf>

Nipple eczema – <https://www.wuth.nhs.uk/media/16207/nipple-eczema-version-1.pdf>

Nipple discharge - <https://www.wuth.nhs.uk/media/15868/abs-summary-statement-nipple-discharge-v1.pdf>

Gynaecomastia – <https://www.wuth.nhs.uk/media/15869/abs-summary-statement-gynaecomastia-2019.pdf>

|  |
| --- |
| PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD |
| 1. This for is for both 2WW Cancer Referral and 2WW Symptomatic clinics. Has the patient been advised appropriately? If cancer is suspected the patient should be informed and given a 2WW cancer information letter YES [ ]

If no, explain why: |
| 1. Have you ensured that the telephone contact details are correct? Yes? [ ]
 |
| 1. Is the patient available for an appointment within the next two weeks? Yes? [ ]
 |
| **REFERRER’S DETAILS** |
| **Referring GP** | (Dr) | **GP Code:** |
| **Registered GP** |
| **GP Address & postcode:** |  |
| **GP Telephone number:** |  |  |
| **GP Gatekeeper email address** |  |  |
| **Date seen by GP:** |  | **Decision to refer date:**Click here to enter a date. |
| **PATIENT DETAILS** |
| **Title and Surname:** |  | **Forename(s)** |  |
| **D.O.B.** | Click here to enter a date. | **AGE:** |  | **Gender** |  |
| **Address:****Postcode:** |  |
| **Telephone No evening** |  | **NHS No:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **2WW Suspected Cancer****Please only use this section if you feel this patient is LIKELY to have Breast Cancer** | [ ]  | **Symptomatic****Cancer NOT suspected** | [ ]  |
| Discrete, hard lump ± fixation, ± skin tethering(any age) | [ ]  | Women aged < 30 years with a lump | [ ]  |
| 30 years and older with a discrete lump that persists post period / menopause | [ ]  | Asymmetrical nodularity or thickening that persists at review after menstruation | [ ]  |
| With **spontaneous unilateral bloody** nipple discharge or which stains clothes | [ ]  | Unilateral, spontaneous, nipple discharge that is persistent or troublesome | [ ]  |
| With nipple retraction or distortion of recent onset (<3 months onset) | [ ]  | Infection or inflammation that fails to respond to antibiotics.**Breast Abscess:** If urgent assessment is required, please discuss with the local team. | [ ]  |
| Skin distortion / tethering / ulceration / Peau d’orange | [ ]  | With unilateral eczematous skin of areola or nipple:Please do not refer until they have tried topical treatment such as 0.1% mometasone daily for 2 weeks. | [ ]  |
| Unexplained lump in axilla | [ ]  | Patients with breast pain alone (no palpable abnormality)Please do not refer until you have tried Primary Care management (6-12 weeks regular NSAID or paracetamol as a minimum) see best practice guidance as cancer is extremely unlikely<https://www.wuth.nhs.uk/media/16210/breast-pain-information-for-gps-2.pdf> | [ ]  |

|  |  |
| --- | --- |
| **Latest Mammogram Result**(If not readcode recorded please add date and result manually) | **Specific Codes Table:** |
| **Date:** Click here to enter a date.**Description:** |

|  |
| --- |
| **Please include information about location and length of symptoms for ALL referrals:** |

**None of the above?** **Unsure about best treatment options for mastalgia or nipple eczema – please contact the team for advice and guidance via this email address which is monitored each week day –**wuth.breastsecretaries@nhs.net

**Family History Clinic – Service Name/ID to select in E-referral Service (ERS)**

**Surgery Breast – Family History Referral Assessment Service – Clatterbridge Hospital RBL 7938621**

**Funding must be approved and attached before referring for cosmetic reasons.**

|  |  |
| --- | --- |
| **Clinical Performance Status** | **Please mark with an X** |
| 0 – Able to carry out normal activity without restriction | [ ]  |
| 1 – Restricted in strenuous activity but ambulatory and able to carry out light work | [ ]  |
| 2 – Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours | [ ]  |
| 3 – Symptomatic and in a chair or in bed for greater that 50% of the day but not bedridden  | [ ]  |
| 4 – Completely disabled; cannot carry out any self-care; totally confined to bed or chair | [ ]  |
| **Consultations:****Date:** Click here to enter a date. **Consultation Text:** |
| **Problems****Active** |
| **Date:** | Click here to enter a date. | **Problem:**  | **Date ended:** | Click here to enter a date. |
|  |
| **Significant Past** |
| **Date:** | Click here to enter a date. | **Problem:** | **Date ended:** | Click here to enter a date. |
|  |
| **Medication:** |
| **Values and Investigations** |
| **Date:** | Click here to enter a date. | **Description:** | **Value:** | **Units:** | **Range:** |
|  |
| **Allergies** |
| **Date:** | Click here to enter a date. | **Description:** |
| **Associated Text:** |

|  |
| --- |
| **CULTURAL, MOBILITY, IMPAIRMENT ISSUES** |
| Does the patient have any communication, mobility or safeguarding needs? |  |
| What is the patient’s preferred first language? |  |
| Does the patient require translation or interpretation services? |  |
| Please list any hearing or visual impairments requiring specialist help (sign language, Braille, Loop Induction Systems)? |  |
| Is disabled access required? | **Yes** | [ ]  | **No** | [ ]  |
| Military veteran status? | **Yes** |[ ]  **No** |[ ]
| In your clinical opinion does the current condition relate to their military service and require priority treatment? |  |
| Are there any safeguarding issues (including lack of capacity) of which we should be aware of? |  |