**LUTON COMMUNITY CANCER CARE TEAM REFERRAL FORM**

**Unit 2-3 The Poynt, Poynters Road, Luton, LU4 0LA**

**Email all referrals to:** [ccs-tr.lutonRMSreferrals@nhs.net](mailto:ccs-tr.lutonRMSreferrals@nhs.net) **Telephone Number:** 0333 405 3000

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| **ALL SECTIONS OF THIS FORM MUST BE COMPLETED BEFORE THE REFERRAL CAN BE ACCEPTED**  **All patients that are referred MUST have a CANCER DIAGNOSIS**  **Patients may receive a one-off assessment, intervention or signposting, or may be accepted onto the Cancer Clinical Nurse Specialists caseload, either short term or long term dependent upon need.**  **If patients require bloods they can be referred to the Phlebotomy service.** | | | | | |
| **Referrals accepted Mon – Fri 8am – 4pm Date:** | | | | | |
| **Patients Name:** | | | **Known As:** | | |
| **Address:**  **Postcode:** | | | | | **DOB:** |
| **Telephone Number:** | | | **Email:** | | |
| **Is the patient aware of the referral? Yes ❒ No ❒ *(Referral will only be accepted if Patient has consented)***  **Is the patient aware of their diagnosis?Yes ❒ No ❒**  **Is carer aware of diagnosis? Yes ❒ No ❒** | | | | | |
| Access Lone Worker Issue to be aware of? Yes ❒ No ❒  Details: | | | | | |
| **NHS Number:** | | | **DIS: Hospital Number:** | | |
| **Ethnic Origin:** | **Religion:** | | | **Interpreter Required?** If yes, Specify: | |
| **Patient’s Carer / Next of Kin (Relationship)** | | | | | |
| **Address if different from above:** | | | | | **Telephone Number:** |
| **GP Practice:** | | | | | **Telephone Number:** |
| **Consultant:**  **Treatment Centre:** | | | | | **Hospital:**  **Telephone Number:** |
| **MEDICAL INFORMATION:**  ***Please attach relevant information such as clinic letters, discharge letters to support referral***  **Diagnosis:**  **Treatment:** Chemotherapy ❒ Immunotherapy ❒ Radiotherapy ❒ Surgery ❒  **Details** *(if chemo, please specify the type of chemo)***:**  **Performance Status (WHO) : 1** ❒ **2** ❒ **3** ❒ **4** ❒ | | | | | |
| **Relevant PMH:** | | **Please list all current medication:** | | | |

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| **URGENCY OF REFERRAL *(please tick)*  Red ❒ Amber ❒ Green ❒** | | | |
| **Red** | **Amber** | | **Green** |
| Patients with intolerable side effects of treatment. UKONs flagged amber and green Oncology patients. (daily discussion with L&D acute oncology service) | Patients that are having routine treatments and non-emergency symptom control.  Delay in treatment needing CVAD care | | Patient routine advice & information.  Psychological support. Signposting.  Career support. |
| These patients will be contacted on the day of the referral. | These patients will be contacted within 2 working days of the referral. | | These patients will be contacted within 5 working days of the referral. |
| **Please note: Incomplete referrals cannot be accepted. Please provide as much information as possible to support the referral/request. Also last HNA**  **REASON FOR REFERRAL – Please give any further information below**  **Symptom Control** ❒ **Psychological Care**❒ **Social Care** ❒ **CVAD Care** ❒  **Other** ❒ | | | |
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| **Expectations for Referral to Luton Community**  **Cancer Care Team:** | | **Referrer’s Name:**  **Contact Details:** | |

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| **Luton Community Cancer Care Team Use Only** | |
| **Referral Received**  **Date/Time:** | **By:** |
| **Referral Accepted: Yes ❒ No ❒ Action taken if declined:** | |
| **Registered on System1: 🞎** | **Date Patient Contacted:** |