Western Sussex Hospitals
NHS Foundation Trust

Suspected Colorectal Cancer 2WR Referral Form

Please indicate hospital patient wishes to attend

☐ **Worthing** ☐ **St. Richard's**

Please fax referrals to 2WR hub: 01903 285098

For Choose and Book referrals, attach this template to a referral in Choose and Book within 24 hours of creating the request

PATIENT DETAILS:	**GP DETAILS**
Forename: **Surname:**	**Name of referrer:**
Address:	**Address:**
Post Code:	**Post Code:**
Date Of Birth:	**Phone Number:**
Sex: M ☐ **F** ☐	**Fax Number:**
NHS Number:	**Date referral sent:**
Hospital Unit Number:	
IMPORTANT: To be able to contact the patient within 48 hours of referral (day and evening) please provide patients preferred contact phone details:	**Home:** **Mobile:** **Work:**

REASON FOR REFERRAL – must be completed (*Please indicate as appropriate by 'checking' box)*

Age 40 and over:

6 weeks or more of

☐ **Rectal bleeding with change of bowel habit to looser/more frequent stools**

Age 60 and over:

6 weeks or more of

☐ **Rectal bleeding with no anal symptoms without change in bowel habit**

Or

☐ **Change in bowel habit to looser/more frequent stools without rectal bleeding**

Any Age:

☐ **Right Lower Abdominal mass consistent with involvement of large bowel**

☐ **Palpable rectal (not pelvic) mass**

☐ **Males with iron deficiency anaemia & Hb less than 11g/100ml;**

☐ **Non menstruating female with iron deficiency anaemia & Hb less than 10g/100ml**

Rectal examination - required for 2 week wait referrals with rectal symptoms
Findings, or reason why not performed:

Other relevant information (e.g. fit for investigation, translator requirements etc)**:**

(PMHx, medications etc may be appended as an attachment)

☐ **Please tick to confirm patient has been made aware of reason for 2WR referral**