Western Health and Social Care Trust

Acute Oncology Service Referral Form

Name of Patient:		**Gender:**	
DoB:		**Admitting Consultant:**	
Hospital number:		**Known Oncology Consultant:**	
Current ward:		**Referrer Name:**	
Date of admission:		**Referrer contact details:**	
New Cancer diagnosis:	Yes ☐ No ☐	**Known Tumour site:**	
If MUO*/CUP suspected, has relevant pathway been followed?**	Yes ☐ No ☐	**Chemotherapy within 6 weeks of admission?**	Yes ☐ No ☐
If not, please provide reason:		**Radiotherapy within 6 weeks of admission?**	Yes ☐ No ☐
Current Oncology problem:			
Describe AOS input required:			
Patient informed of referral to AOS	Yes ☐		

*MUO- Malignancy of Undefined primary Origin CUP** Carcinoma of Unknown Primary

Once complete please email referral form to AOS at: acute.oncology@westerntrust.hscni.net (and bleep AOS Clinical Nurse Specialist on XXXX to confirm receipt).

PLEASE ENSURE ALL SECTIONS ARE COMPLETED TO ALLOW APPROPRIATE TRIAGE

AOS staff Only Date referral information received:		**AOS Staff only Time received:**	