UCATS

– UK Cancer and Transition Service –

UK Cancer and Transition Service – Healthcare Professional Referral Form

This form is for healthcare professionals to refer trans, non-binary and gender diverse patients where they have queries or concerns around the interplay between a patient's cancer diagnosis and treatment and their gender identity or hormones / surgeries that form part of their transition.

If you are a patient, please use the alternative patient form.

For able us to discuss your patient at our MDT, we require as much clinical detail as possible about their cancer and their transition. They do not need to have been a patient of a gender identity clinic to be discussed. Please ask the patient for any information you do not know, and please make them aware of this referral. Please enclose any relevant correspondence.

If appropriate, a clinic appointment will be offered in addition to the MDT discussion.

Please return this form to: chelwest.ucats@nhs.net

Patient details:

We aim to discuss within one month so please not allow this discussion to delay urgent treatment.

Surname		NHS No	
First Names		Hospital Number	
Title & Pronouns used		Address	
Date of birth		Post code	
Sex assigned at birth		Gender Identity	
Mobile Number		Email address	

Brief outline of any specific question(s) being asked:

Cancer History

Tumour Type:

Age / year of diagnosis:

Grade:

Size:

Lymph nodes positive:

TNM Stage:

Metastatic sites:

For chest/breast and other hormones receptive tumours:

ER:

PR:

HER2

AR (if done):

Somatic genomic testing:

Germline genomic testing:

Detected by: Patient / Screening / Incidental on imaging / Incidental at surgery

Radiotherapy:

Chemotherapy/Hormonal therapy:

Chemotherapy/Hormonal therapy:

Date (from/to)

Setting (eg adjuvant)

Agent(s)

Response

Current stage and metastatic sites (if different from above and visible disease):

Family history of cancers (please give tumour type, family member and age at diagnosis):

Additional Medical history:

Other Medications:

Allergies

Gender Affirming Care

Current / previous gender identity clinic(s) / private providers:

Name Date(s)

Current hormone therapy:

Agent Dose

Frequency Duration

Past hormone therapy (please * if self-medication):

Agent Dose

Frequency Duration

Previous surgery if assigned female at birth:

Bilateral mastectomy and male chest reconstruction: Yes / No Date:

Hysterectomy and bilateral salpingoophorectomy: Yes / No Date:

Previous surgery if assigned female at birth:

Female breast augmentation: Yes / No Date:

Orchidectomy / Vaginoplasty / Vulvoplasty Yes / No Date:

Additional risk factors:

Smoker? Current / past / never Cig / day

For those assigned female at birth only – please only complete if patient is happy to discuss.

Age of menarche:

Contraceptive use (type and dates, current and historical):

Number (if any) of full term pregnancies:

Age at menopause (if any):

Details of person completing this form:

Name:		Grade:	
Speciality:		NHS trust email:	
Tel no:		NHS Email:	

Does the patient consent to us contacting the following for additional clinical details?

Consent to the UCATS team contacting cancer specialist Yes / No

Consent to the UCATS team contacting gender specialist Yes / No

Consent to the UCATS team contacting GP Yes / No

PRINT NAME:_____

SIGNATURE: