UK Cancer and Transition Service – Patient Self-Referral Form

This form is for patients who have concerns about how their cancer diagnosis may be affected by hormones or surgeries that part of their transition, and would like their case discussed at our meeting of specialist health professionals. If appropriate, you will also be offered a clinic appointment.

You can also ask your doctor to fill in the clinical referral form. If you are a doctor looking to refer a patient, you should fill in that form.

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

For able us to discuss your case, we need permission to contact your doctor and to collect clinical information from you:

I consent to the UCATS team contacting my cancer specialist

I consent to the UCATS team contacting my gender specialist

I consent to the UCATS team contacting my GP

PRINT NAME:____________________________

SIGNATURE:

DATE:

Your details:

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	

Your Cancer consultant's details:

Name:

Specialty:

Hospital:

Secretary Tel No:

Your Gender Identity Clinic / Care Provider details:

Clinic Name:

Specialty:

Last clinician you saw:

Secretary Tel No:

Your GP's details:

Name:

Address:

Practice Name:

Tel No:

Cancer History

Please fill in these details as best you can and also enclose last lessons from any doctors treating your cancer.

Brief outline of your cancer history and any specific question(s) being asked:

Tumour Type:

Age / year of diagnosis:

Detected by: You / Screening / Found by chance on a scan / Found by chance at surgery

Surgery to-date:

Radiotherapy:

Chemotherapy/Hormonal therapy:

Date (from/to)

Drug(s)

Family history (please give family member and age at diagnosis):

Additional Medical history:

Other Medications:

Allergies:

Gender Affirming Care

Please fill in these details as best you can and also enclose last lessons from any doctors treating your cancer.

Current / previous gender identity clinic(s)

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:

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:

Age of starting periods:

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

Number (if any) of full term pregnancies:

Age at menopause (if any):