



Chelsea and Westminster Hospital
NHS Foundation Trust

In partnership with



- 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:

- The clinician or patient has a query or concern around the interplay between the patient's cancer diagnosis and treatment, and their gender identity or hormones /surgeries that form part of their transition.
- The patient requires additional support with gender and cancer.
- The patient would like to be considered for our research cohort.

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

To enable us to discuss your patient at our MDT and to triage this referral, 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 and clinic letters.**

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

Please return this form to: chelwest.ucats@nhs.net. If the case is urgent, please put this in the subject line.

We aim to discuss within one month so please do not allow this to delay urgent treatment while awaiting UCATS input.

Please tell us the reason for the referral, including any specific questions or concerns.

Patient Details

Title and Pronouns		NHS Number	
First Name(s)		Surname	
Name known to GP *if different		Date of Birth	
Address		Post Code	
Gender Identity		Sex Assigned at Birth	

Mobile Number		Email Address	
Ethnicity		Hospital number *if applicable	
Access needs or adaptations			

Cancer History

Please also send us any recent letters from the cancer consultant, if available.

Tumour type			
Age / year of diagnosis		Size	
Grade		Lymph nodes positive	
TNM / Other Stage		Metastatic sites	
Current stage and metastatic sites (if different from above and visible disease)			
Family history Please give tumour type, family member, and age at diagnosis			

For chest/breast and other hormone 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	
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Chemotherapy/Hormonal therapy Dates, setting, agent(s), response	
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Other Medical History

Additional medical history	
Other medications	
Allergies	

Gender Affirming Care

Please also send us any recent letters from the gender consultant, if available.

Current hormonal therapy Medication, dose, frequency, response please * if self medication	
Past hormonal therapy Medication, dose, frequency, response please * if self medication	
Gender affirming surgeries Please include dates if applicable	
Additional information	

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 patient name	
Patient signature can be electronic or typed	

Role of person filling out this form: Cancer clinician / Gender clinician / GP /Other

Cancer consultant's details

Name	
Specialty	
Hospital	
Phone number / email	
Email for sending clinic letters	

Gender Identity Clinic / Care Provider's details

Clinic name	
Specialty	
Phone number / email	
Email for sending clinic letters	

GP's details

Named GP or last clinician seen	
Practice name	
Address	
Phone number / email	

Where did you find out about UCATS?

Conference / Training / Colleague / Macmillan / Online / Other: _____