The Liverpool High or Elevated Level of Platelets (HELP) Flag: GP Handbook

04 February 2026 (version 2.0)

1.1 What is HELP Flag?

HELP Flag is an innovation that aims to support GPs to identify and triage patients with raised platelet count. It consists of:

1. A line of guidance that will appear on blood test results for patients whose platelet count exceeds the HELP Flag thresholds, with a note that the platelet count is raised and suggesting investigation on the HELP Flag pathway
2. An accompanying pathway to advise on how to investigate flagged patients

1.2 When will HELP Flag go live?

The go live date for HELP Flag is 2nd February 2026.

1.3 What's different about HELP Flag compared to the usual reporting of platelet count?

- In England, the standard upper threshold for the platelet count is 400 or 450 x 10^9/l, depending on the laboratory.
- We know that platelet count varies by age and sex, being higher in women and decreasing with age.
- HELP Flag harnesses that natural variation to identify patients who would benefit from investigation on the HELP Flag pathway.
- The standard reporting of platelet count will not change. HELP Flag is an additional line of advice on blood test results.

1.4 What is the likely impact of HELP Flag?

- In an audit of routine anonymised data from the Royal Devon University Healthcare NHS Foundation Trust, around 1% of primary care-ordered full blood count tests in adults aged 60 and over showed a platelet count above the HELP Flag thresholds.
- 5.89% of these patients were diagnosed with any cancer type (excluding non-melanoma skin cancer) within 12 months of their blood test.
- The most commonly diagnosed cancers were:
    - Lung (37% of all cancers in flagged patients)
    - Colorectal (36%)
    - Prostate (15%)
    - Renal (7%),
    - Stomach (4%)

- Prostate cancer is not associated with increased platelet counts. The 15% of prostate cancer in this cohort is likely to reflect the fact that it includes a high proportion of men aged 50 years and over.

1.5 How was HELP Flag developed?

HELP Flag was developed following stakeholder engagement which identified that GPs wanted advice and guidance on when and how to investigate patients with raised platelets – and on when not to investigate. The thresholds were informed by peer reviewed research (see below). The HELP Flag pathway was developed by the Peninsula Cancer Alliance and the University of Exeter with input from multiple clinical groups.

1.6 What's the evidence underpinning HELP Flag?

1. The clinical utility of the platelet count as a marker of lung cancer was first established in 2005 (Hamilton *et al* 2005). In that study of 247 lung cancer cases and 1235 matched controls from general practices in Exeter, the positive predictive value for lung cancer associated with thrombocytosis (platelet count > 400 x 10^9/l) was 1.6% (95% confidence interval 0.8 to 3.1).

2. In a cohort study of 40,000 patients with thrombocytosis (Bailey *et al* 2017), 11.6% (95% CI 11.0 to 12.3) of males aged 40 years and over were diagnosed with cancer in the following year (any site excluding non-melanoma skin cancer). The equivalent figure in females was 6.2% (95% CI 5.9 to 6.5). The risk of cancer increased to 18.1% (95% CI = 15.9 to 20.5) for males and 10.1% (95% CI = 9.0 to 11.3) for females when a second raised platelet count was recorded within 6 months. Lung and colorectal cancer were more commonly diagnosed with thrombocytosis.

3. Thrombocytosis is listed as a clinical feature of lung and endometrial cancer in the latest version of NICE guideline NG12 (Suspected cancer: recognition and referral), published in 2015.

4. A study of patients with platelet counts at the upper end of the normal range (Mounce *et al* 2020) found that men aged 60 years and over with a platelet count of 326 – 400 × 109 /l had a 1-year cancer incidence of over 3%.

5. Studies of patients with thrombocytosis in Ontario have also reported an elevated cancer risk associated with the test result (Giannakeas and Narod 2021 and Giannakeas et al 2022).

1.7 Which cancers are most likely in patients with raised platelet counts?

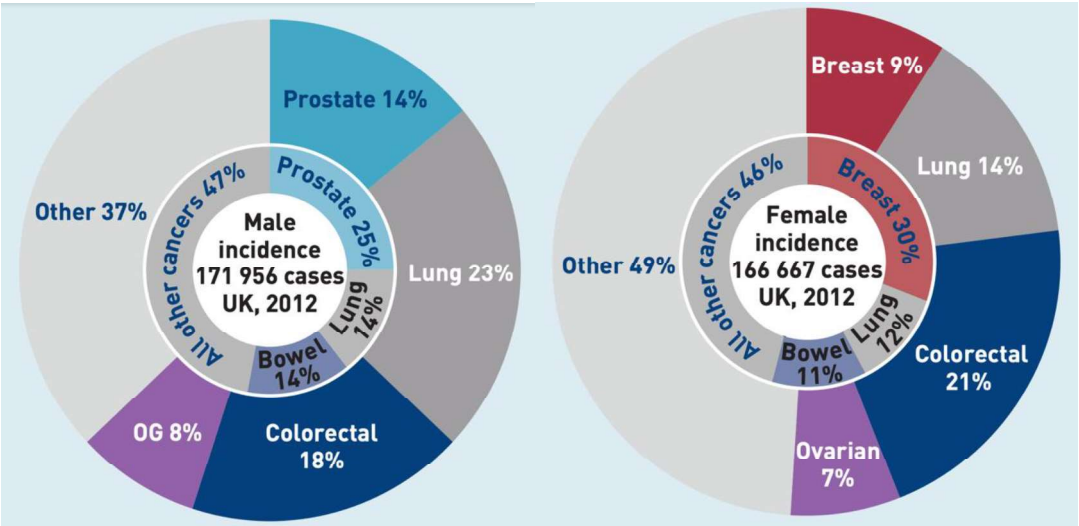


Figure 1: Sites of cancer diagnosis in males (left) and females (right) with thrombocytosis, compared with sites of malignancy in the general population. The outer ring shows the cancers diagnosed in patients with thrombocytosis and the inner ring shows incidence in the general population. OG = oesophagogastric.

These figures relate to cancers in patients with platelet counts of >400x10^9/l, not with platelet counts above the HELP Flag thresholds.

1.8 Should I do a blood test to check for raised platelets?

All evidence on the link between platelet count and cancer diagnosis is based on primary care blood tests that were ordered for any reason. The initial reason for the test could have been investigation, monitoring, or reassurance, but there is an assumption that the test was ordered in patients who were not asymptomatic – there was a clinical reason for the initial consultation and for the FBC. There is no evidence that the platelet count is a useful screening tool (i.e. case finding in otherwise asymptomatic patients).

1.9 How should I respond to patients who request a platelet count who are otherwise fit and well?

The risk of cancer is low in patients who are asymptomatic, and the chance of a false positive test is higher if the test is used in asymptomatic patients. This could mean that the patient is wrongly told that they might have cancer, and they may be subjected to other tests and investigations unnecessarily.

If the patient is otherwise fit and well, there is no need to be concerned about (or measure) the platelet count.

1.10 What about patients who have undergone gender reassignment?

Liverpool Clinical Laboratory currently process results based on the gender that is reported on the request form and will therefore apply the algorithm in accordance with what is reported.

1.11 What is positive predictive value?

The positive predictive value represents the percentage of patients with a particular feature or test result who have the disease in question. For example, the PPV for breast cancer of a breast lump is about 8%; meaning approximately 8% of patients with a record of breast lump are subsequently diagnosed with breast cancer.

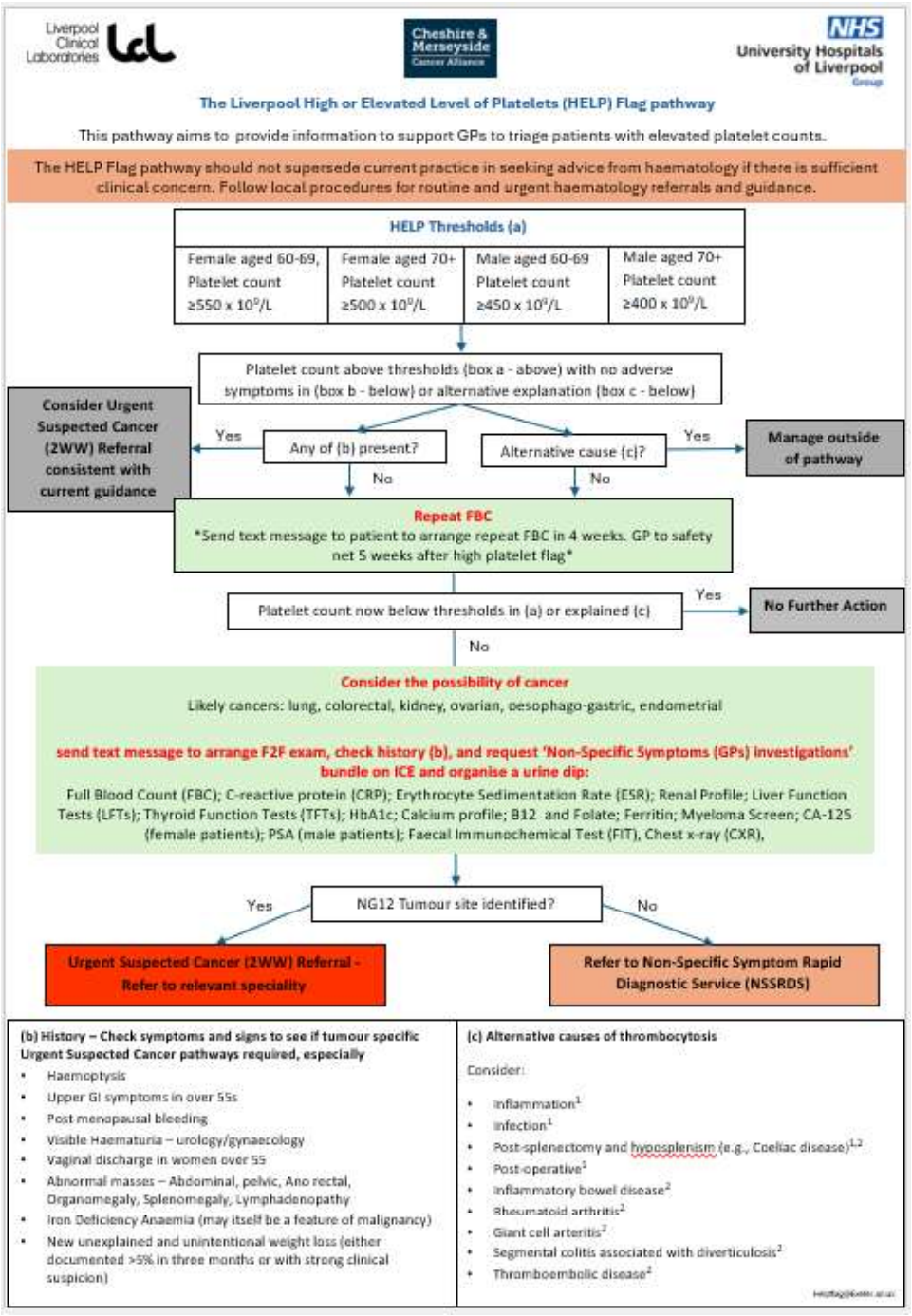
1.12 What is the 95% confidence interval?

The 95% confidence interval is a range that is commonly reported alongside an estimate of an effect, such as the percentage of patients with an abnormal test result who have cancer. We can be 95% certain that if we measured everyone in the population with that test result, the true value would like somewhere in that range.

1.13 Who should I contact if I have any questions?

You can contact the HELP Flag team at the University of Exeter if you have any questions via email (helpflag@exeter.ac.uk). They have been supporting Cheshire and Merseyside Cancer Alliance with the implementation of HELP Flag.

1.14 The Liverpool High or Elevated Level of Platelets (HELP) Flag pathway



1.15 The Liverpool High or Elevated Level of Platelets (HELP) Flag raised platelets guidance

Advice on the association between cancer and elevated platelet levels has been available since the publication of the NICE guideline on referral for suspected cancer, NG12, published in 2015. Thanks to the continued investigation of this relationship by researchers at the University of Exeter, we are able to offer clarification on the thresholds at which primary care clinicians should consider additional investigations and possible onward referral via an Urgent Suspected Cancer (formerly 2WW) pathway. This work was funded by David Walton as part of the Hideko Walton project.

This guideline is intended to supplement existing guidance on whether elevated platelet levels need referral for a haematology opinion and should be viewed in tandem with it. It is important to note that this guideline is based on specific thresholds for elevated platelets – in the absence of concerning symptoms, signs or other test findings, most patients with modest platelet elevation do not need investigation to exclude cancer.

The pathway can also be found at https://www.uhliverpool.nhs.uk/download_file/20322/0

- **Scope**

This guidance is intended to supplement the existing guidance on when to refer for investigation of a haematological cause and is intended to help clinicians find the most appropriate non-haematological investigation or referral for their patient.

Thrombocytosis is an increase in platelets typically more than ≥400 x 10^9/L, commonly found incidentally in a blood test. Platelet count naturally varies by age and sex and can be a marker of undiagnosed cancer.

Patient groups with a 7+% risk of cancer, considered 'high risk' and requiring attention, are:

- **Women aged 60 to 69 years with a platelet count ≥550 x 10^9/L.**
- **Women aged 70 years and over with a platelet count ≥500 x 10^9/L.**
- **Men aged 60 to 69 years with a platelet count ≥450 x 10^9/L.**
- **Men aged 70 years and over with a platelet count ≥400 x 10^9/L.**

Patients meeting the above criteria will be identified to the primary care clinician using messaging on the pathology reporting system.

The most common cancers occurring in these groups are lung, colon, renal and stomach.

Adult patients with a platelet count ≥400 x 10^9/L who do not fit into these age/sex/platelet categories should be managed using local or national clinical guidance.

1. Possible non-cancer explanations for raised platelets

Thrombocytosis can be caused by:

- Inflammation[1]
- Infection[1]
- Post-splenectomy and hyposplenism (e.g., Coeliac disease)[1,2]
- Post-operative[1]
- Inflammatory bowel disease[2]
- Rheumatoid arthritis[2]
- Giant cell arteritis[2]
- Segmental colitis associated with diverticulosis[2]
- Thromboembolic disease[2]

2. Raised platelets in combination with concerning symptoms or signs

The following features in combination with raised platelets at the thresholds above should prompt the clinician to consider referral to an urgent suspected cancer pathway without repeating the full blood count after a delay.

- Haemoptysis
- Upper GI symptoms in over 55s
- Post menopausal bleeding
- Visible Haematuria – urology/gynaecology
- Vaginal discharge in women over 55
- Abnormal masses – Abdominal, pelvic, Ano rectal, Organomegaly, Splenomegaly, Lymphadenopathy
- Iron Deficiency Anaemia
- New unexplained and unintentional weight loss (either documented >5% in three months or with strong clinical suspicion)

Suspected Cancer Pathway Selection and Pre-referral testing

Raised platelets in combination with one of the findings above should prompt Urgent Suspected Cancer (formerly 2ww) referral.

In some cases selection of a site-specific referral will be clearly indicated. Examples might include Iron Deficiency Anaemia or a combination of abdominal pain and weight loss.

If a site-specific referral is not clearly indicated, the following Non-Specific Symptoms Rapid Diagnostic Service (**NSSRDS) investigation bundle** plus urine dip test should be arranged to assist decision making:

- Full blood count
- ESR and CRP
- LFTS (including globulins)
- TFTS
- Renal profile
- HBA1c
- Calcium profile
- CA-125 (women)
- PSA (men)
- B12 & Folate
- Ferritin
- Myeloma screen
- Faecal Immunochemical Test (FIT)
- Chest X-Ray

- Patients with raised platelets and no concerning symptoms

1. If high platelet count at the flagged thresholds above is not explained by a non-cancer cause (para 1) or associated with concerning cancer symptoms (para 2), repeat FBC in 4 weeks and then:

   If platelet count remains above the flagged threshold, arrange a face to face consultation with the patient, check history, conduct examination including urine dipstick, and order NSSRDS investigation bundle as above

2. If history or examination do not meet criteria for a tumour specific urgent suspect cancer pathway then consider referral to the Non-Specific Symptoms Rapid Diagnostic Service (NSSRDS) Urgent Suspected Cancer clinic **NOW** AND arrange NSSRDS bloods CXR and FIT urgently.

   Note: For NSSRDS referral, results must be no older than 3 months. If TFTs, HbA1c, B12/Folate, Ferritin, and Myeloma Screen done within last 2 months they may not need repeating.

3. If platelet levels have decreased at the second FBC, take no further action.

- Patient communication

If arranging a second FBC, practice to send text message to patient:

"Your platelets are raised. Please book another blood test in 4 weeks. If repeat normal, no action. If still raised make a GP appt. Any queries please ring us.

If platelet count remains high at second blood test, send text message to encourage patient to come in:

"Your repeat blood test showed your platelets are still raised. Please contact the surgery to arrange a GP appointment to discuss further tests."

During the consultation, counsel the patient to help them understand the NSSRDS process. Note that unexplained persistent raised platelets may be an early sign of cancer and NSSRDS is warranted. Reassure the patient that the test results from NSSRDS are expected within 28 days and that 90% of patients referred will not have cancer. If the NSSRDS tests do not reveal anything then explain that they may be referred to haematology for further investigation.

- Safety netting

Patients with an initial unexplained high platelet count need a second FBC to confirm whether the elevated platelet count persists and requires further investigation. GPs handling FBC results should confirm that there is no previous recent elevated platelet count before arranging the second FBC test.

GP practices should follow their usual safety netting processes to ensure patients with an initial unexplained high platelet count have a second FBC test 4 weeks after the initial test. Example safety netting processes could include an EMIS/SystmOne diary entry with a practice process for checking and actioning these entries or scheduling a reminder text message for the patient via AccuRx.

Patients with persistently elevated platelets on the second FBC tests should have an appointment arranged to discuss the result with an appropriate clinician, as would be the case for any patient with an abnormal test result that could lead to an urgent suspected cancer referral (i.e. unexplained IDA or elevated PSA).

- Referral

If referring via an Urgent Suspected Cancer (formerly 2ww) pathway or via NSSRDS, *please ensure to complete all pre-referral tests and to complete the referral form with all requested information.*

If no cancer is found following NSS, no onward referral necessary unless the patient meets the criteria for another existing pathway (such as haematology) in which case refer as usual using local criteria.

1.16 Referral Forms

Urgent Suspected Cancer (2WW)

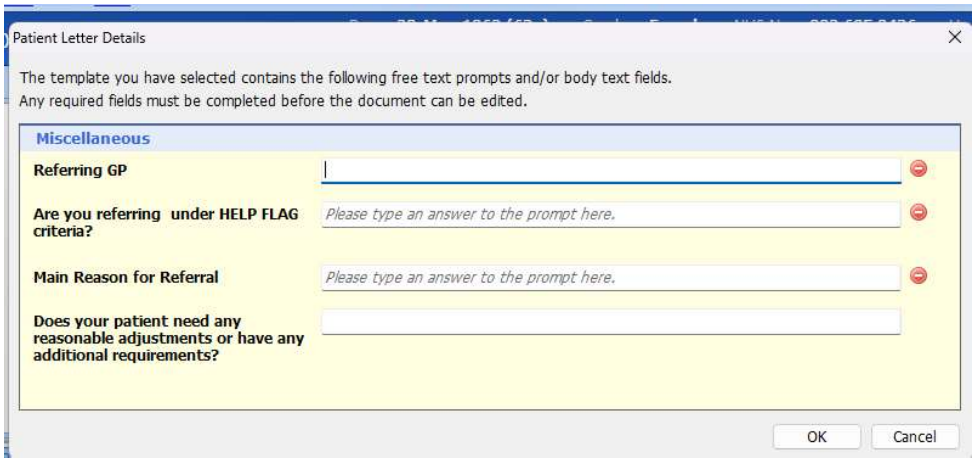
Please refer electronically on ERS under '2 week wait', urgent suspected cancer and safety net

Urgent Suspected Cancer (2WW) Referral Forms :: Cheshire & Merseyside Cancer Academy

Non-Specific Symptoms Rapid Diagnosis Service (NSSRDS)

Use form stored on practice IT system.

There will be a prompt upon opening the form as per below:



Please ensure that this is completed in full and make sure you type 'Yes' or 'No' when indicating whether you are referring under the HELP Flag criteria. The answer you provide here will appear in red under the 'referral information' section of the form.

A template NSSRDS referral form can be found in the appendix of this handbook and a digital copy will have been shared with your practice.

To reiterate – when making an NSSRDS referral please clearly indicate that you are referring under HELP Flag criteria (indicate this on the pop-up box as seen above and check the 'referral information' section of the form states that 'yes', you are referring under HELP Flag criteria.

NSSRDS Referral criteria can be found here:

https://www.uhliverpool.nhs.uk/application/files/6517/0842/2001/NSSRDS_information_v1.24_RR_changes_002_updated.pdf

1.17 Supporting Information

See: Mounce LTA, Calitri R, Hamilton W, Rafiq M, Emery JD, Giannakeas V, Kotsopoulos J, Bailey SER. Improving the Clinical Utility of Platelet Count for Cancer Detection in Primary Care: A Cohort Study in England, Canada, and Australia. Cancers (Basel). 2024 Sep 4;16(17):3074. doi: 10.3390/cancers16173074. PMID: 39272932; PMCID: PMC11394200.

Supporting Literature:

Herefordshire & Worcestershire Integrated Care System (2023). Haematology Guidance for Clinicians. Version 1. https://herefordshireandworcestershireccg.nhs.uk/policies/clinical-medicines-commissioning/clinical-policies-and-guidance/nutrition-and-blood/1386-haematology-guidelines-for-clinicians-v1/file (accessed 22/09/23).

King's Health Partners (2022). Haematology GP referral Guide, Adult Haematology. Version 2. https://www.kingshealthpartners.org/assets/000/005/128/KHP_KCH_Joint_Adult_Haematology_GP_Referral_Guide_Version_2_original.pdf. (accessed 22/09/23).

Manchester University NHS Foundation Trust (2021). Adult Haematology GP Pathway Guides. Draft V.4. https://mft.nhs.uk/app/uploads/2021/02/MFT-Haematology-GP-Pathway-Guide-v4-11.2.21.pdf (accessed 22/09/23).

McGregor (2020). GP adult Haematology Guidelines. The Newcastle Upon Tyne Hospitals NHS Foundation Trust. https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2021/02/Adult-haematology-guidelines-v9.pdf (accessed 22/09/23).

Morgan, S & Mohamedbhal, S (2023). Abnormal Full Blood Count (FBC) in Adults Primary Care Clinical Pathway. https://gps.northcentrallondon.icb.nhs.uk/pathways/abnormal-fbc-results-1 (accessed 22/09/23).

Morgan, S & Wamer, A (2015). Abnormal FBC Results Guidance. NHS Camden Clinical Commissioning Group. V1.16. https://gps.northcentrallondon.icb.nhs.uk/cdn/serve/pathway-downloads/1456246258-2f3891e610beaa6533f2c0ad7866e776.pdf (accessed 22/09/23).

NICE (2021). Platelets – abnormal counts and cancer: Scenario: Management of platelet count outside the normal range. https://cks.nice.org.uk/topics/platelets-abnormal-counts-cancer/management/management/#:~:text=within%202%20weeks).-,For%20people%20in%20whom%20cancer%20is%20not%20suspected%20with%20platelet,20%20%C3%97%20109%2FL. (accessed 22/09/23).

North & East Devon Formulary & Referral. Thrombocytosis (High Platelets). https://northeast.devonformularyguidance.nhs.uk/referral-guidance/eastern-locality/haematology/thrombocytosis-high-platelets (accessed 22/09/23).

Peninsula Cancer Alliance. Non-Specific Symptom Pathway: https://peninsulacanceralliance.nhs.uk/non-specific-symptom-pathway/ (accessed 22/09/23)

Causes of Thrombocytosis:

[1] Morgan, S & Mohamedbhal, S (2023). Abnormal Full Blood Count (FBC) in Adults Primary Care Clinical Pathway. https://gps.northcentrallondon.icb.nhs.uk/pathways/abnormal-fbc-results-1 (accessed 22/09/23).

[2]Clarke C, Hamilton W, Price S, Bailey SE. Association of non-malignant diseases with thrombocytosis: a prospective cohort study in general practice. Br J Gen Pract. 2020 Nov 26;70(701):e852-e857. doi: 10.3399/bjgp20X713501. PMID: 33199294; PMCID: PMC7679146.

Symptoms of suspected cancer (informing Box B of pathway):

Suspected Cancer: recognition & referral Nice Guideline (NG12):
https://www.nice.org.uk/guidance/ng12/chapter/recommendations-organised-by-symptom-and-findings-of-primary-care-investigations#bleeding

1.18 Acknowledgements

With thanks to David Walton for his support of the foundation research underpinning the creation of the HELP Flag thresholds and template pathway. Thanks to the NHS Cancer Programme and SBRI Healthcare for funding the early implementation and evaluation of HELP Flag in practice.

Appendix: NSSRDS Referral Form Template

URGENT SUSPECTED CANCER REFERRAL FORM FOR ADULTS
SUSPECTED CANCER NON-SPECIFIC SYMPTOMS (NS) or SUSPECTED METASTATIC (includes patients with radiology suggestive of Metastases of Unknown Origin)

Advice and Guidance should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical

Referral Criteria – see section below

- Patient has non -specific symptoms for suspected cancer which do not meet a site-specific urgent suspected cancer (2WW) pathway
- Consider referral to NS rapid diagnostic service patients with suspected cancer with non-specific symptoms with previous history of cancer and not in routine follow up
- There is a suspicion the patient has metastatic disease

Exclusion criteria for non-specific symptoms

- Patient has specific symptoms warranting referral on to a site-specific urgent suspected (2WW) cancer pathway in line with NICE NG 12 suspected cancer referral guidance
- Patient is too unwell or unable to attend as an outpatient or needs acute admission
- Patient is likely to have a non-cancer diagnosis and is therefore suitable for another specialist route
- Patient is currently being investigated for the same problem by another specialist team.

PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD

Has the patient been counselled they are being referred to a suspected cancer service and the reason for referral? NICE ng12 guidance/ patient support	Yes ☐ No ☐
Has the patient been given relevant written information about this referral? Single Code Entry: Provision of written information about 2 week wait referral	Yes ☐ No ☐
Is the patient available within the next 14 days? If selected no, please explain why?	Yes ☐ No ☐
Have you checked all contact details are correct and informed the patient that the initial appointment may be by telephone?	Yes ☐ No ☐

REFERRER DETAILS

Referring GP	Free Text Prompt	GP Code	Usual GP Organisation National Practice Code
Usual GP	Usual GP Title Usual GP Forenames Usual GP Surname		
GP Address	Usual GP Full Address (single line)		
GP Tel. No.	Usual GP Phone Number		
GP secure email	Organisation E-mail Address		
Date seen by GP	Long date letter merged	Decision to refer date	Long date letter merged

PATIENT DETAILS

Title & Surname	Title **Surname**		Forename(s)	**Given Name**		
Date of Birth	**Date of Birth**	Age Age	NHS Number **NHS Number**	Gender	Gender(full)	
Address	Home Full Address (single line)					
Home Tel No.	Patient Home Telephone	Work Tel No.	Patient Work Telephone			
Mobile Tel No.	Patient Mobile Telephone	Patient email	Patient E-mail Address			
Next of Kin/Chosen		Name and contact details if patient	Single Code Entry: Patient's next of			

NHS Number Given Name Surname

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If changes are required, please contact CMCA ccf-tr.primarycareengagement.nhs.net to ensure appropriate governance and version control

representative **Permission Given:**	Yes ☐ No ☐	gives permission to speak to them.	kin

REFERRAL INFORMATION

Main Reason for Referral NG 12 Guidance : Non-Site-Specific Symptoms

Are you referring under Help Flag Criteria? Free Text Prompt

Free Text Prompt

PLEASE COMPLETE:

History, examination and core investigations prior to referral. This is to ensure that your patient would benefit from non-specific service rather than a site specific suspected cancer referral.

REFERRAL CRITERIA	
New unexplained and unintentional weight loss of more than 5% in the last 3 months or with strong clinical suspicion	Yes ☐ No ☐
Abnormal blood tests with no indication of a clear referral pathway	Yes ☐ No ☐
New unexplained constitutional symptoms of four weeks or more (less if very significant concern)	Duration and description of symptoms
• Nausea	Yes ☐ No ☐
• Loss of appetite	Yes ☐ No ☐
• Fatigue	Yes ☐ No ☐
• Bloating	Yes ☐ No ☐
• Sweats	Yes ☐ No ☐
New unexplained vague abdominal pain of four weeks or more (less if very significant concern)	Yes ☐ No ☐
New unexplained, unexpected or progressive pain, including bone pain, of four weeks or more	Yes ☐ No ☐
GP 'gut feeling' of cancer diagnosis Please describe	Yes ☐ No ☐
Abnormal radiology suggesting cancer which does not meet criteria for site specific pathway.. (While it is helpful to request core blood tests, do not wait for results if radiology suggestive of Cancer of unknown origin)	Yes ☐ No ☐ please ensure report attached

INVESTIGATIONS

Core Tests (essential)	**Consider (depending on presentation and previous results)**
Full Blood Count ESR Thyroid FT Liver FT (including globulins) U&E with eGFR HbA1C CRP Bone Profile	Haematinics (if patient has had an abnormal blood count) • B12 • Folate • Ferritin Myeloma Screening (dependent on patient presentation) PSA (if clinically appropriate)

NHS Number Given Name Surname

Dipstick Urine Test Chest X-Ray (if not had in last 3mths and is medically fit)	CA125 (if clinically appropriate) (women only) FIT (If patient eligible)
Please ensure results of any diagnostic test that has been completed are attached	
CLINICAL PERFORMANCE STATUS	
WHO performance status and if patient is 65 years or over a Clinical Frailty (Rockwood) scale is requested. Please involve your patient in this assessment.	
0. Able to carry out normal activity without restriction **1.** Restricted in strenuous activity but ambulatory and able to carry out light work **2.** Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours **3.** Symptomatic and in a chair or in bed for greater that 50% of the day but not bedridden **4.** Completely disabled; cannot carry out any self-care; totally confined to bed or chair **WHO Performance Score:** Single Code Entry: WHO performance status finding	
Rockwood 1.Very fit; 2.Fit; 3. Managing Well; 4.Vulnerable; 5.Mildly Frail; 6.Moderately frail; 7.Severely frail; 8.Very severely frail Rockwood CFS Descriptors Rockwood Top Tips Single Code Entry: CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale level 1 - very fit...	
CULTURAL, MOBILITY STATUS AND ASSISTANCE REQUIREMENTS	
Does the patient have any Communication, Mobility or Safeguarding needs (Including reduced capacity)? If patient has reduced capacity, please ask permission to speak to next of kin/chosen representative and enter those contact details in "patient details" section on page 1.	Yes ☐ No ☐ Single Code Entry: Impaired vision Single Code Entry: Impaired mobility Single Code Entry: Hearing loss Single Code Entry: No known disability
Please detail if there are any reasonable adjustments needed or additional requirements	Free Text Prompt
If the patient requires Translation or Interpretation Services **Please give details**:	Interpreter required
What is the patient's preferred first language?	Main Language
LGBQT+ Status if patient wishes it to be added	
Ethnicity	Ethnic Origin
Religion (if recorded)	Religion
Temporary resident	Yes ☐ No ☐
Overseas visitor	Yes ☐ No ☐
Military Veteran Status	Yes ☐ No ☐ Single Code Entry: Military veteran
In your clinical opinion, does the current condition relate to their military service and require priority treatment. **Please give details**:	Yes ☐ No ☐
Consultations	
Problems	
Values and Investigations	
Medication	
Allergies	