**BNSSG Suspected CHILDREN’S Cancer Referral Form**

**All referrals should be sent via e-RS with this form attached within 24 hours**

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| Surname First name DOB  NHS Number  Referral Date  Local Centre: BRHC (Bristol, South Glos)       Seashore Centre WGH (North Somerset) |
| **PLEASE REVIEW REMEDY GUIDANCE BEFORE REFERRING FOR POSSIBLE CANCER IN A CHILD** |
| **PLEASE REFER SUSPECTED LYMPHOMA (NOT ISOLATED LYMPHADENOPATHY), LEUKAEMIA, WILMS TUMOUR, HEPATOBLASTOMA OR BRAIN TUMOUR (WITH RED FLAG SIGNS) TO CHILDREN’S EMERGENCY DEPARTMENT FOR SAME DAY ASSESSMENT** |
| ***The majority of lymphadenopathy is benign and doesn’t need paediatrician assessment, guidance is available on Remedy to support primary care assessment*** |
| 1. **REASON FOR REFERRAL – ESSENTIAL** |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:*** |
| **Cancer type suspected** |
| Brain Tumour (consider ED review)  Neuroblastoma  Soft Tissue Sarcoma  Bone Sarcoma  Retinoblastoma  Skin Cancer  Testicular Cancer  Unknown  **Suspected Wilm’s Tumour, Leukaemia, Lymphoma, Hepatoblastoma** **= Same day ED assessment**  **Retinoblastoma = give parents a referral letter and advise them to take the child to BEH A+E on the same/next day.** |
| **Clinical features (list not exhaustive, please detail in reason for referral)** |
| **General:**  Unexplained weight loss  Appetite loss  Unexplained fatigue/malaise/lethargy  Persistent nausea/vomiting  Profuse night sweats  Unexplained pruritus  Unexplained persistent infection  Unexplained shortness of breath  Pallor or other signs of anaemia  Lymphadenopathy with red flag features  Unexplained persistent vague symptoms (3≥ consultations) |
| **Pain:**  Bone pain  Abdominal pain  Headache with concerning features (please see guidance on Remedy)  **Headache with red flag features = Same Day ED assessment (Please see guidance on Remedy)** |
| **Neurology:**  Weakness  Swallowing difficulties in absence of local cause  Ataxia  Torticollis  Facial nerve weakness  Behavioural change or deterioration in developmental milestones/school performance  **Seizures; follow fits/faints/funny turns BCH pathway** |
| **Other:**  Unexplained soft tissue lump  Skin lesions or changes including oedema  Testicular mass  Unexplained visible haematuria  Unexplained bone swelling  **Absent Red Reflex** –Send BEH ED with a letter for same/next day review  **Abdominal mass, Hepatomegaly, Splenomegaly = Same Day ED assessment unless well child with alternative explanation for findings** |

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| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL** | |
| **Other access needs -** *please detail per the selected options in the field below* | |
| Interpreter required If Yes, Language:  Transport required  Wheelchair access required | Learning disability  Mental health issues that may impact on engagement |
| Details of access needs: | |
| 1. **ADDITIONAL IMPORTANT CLINICAL INFORMATION - ESSENTIAL** | |
| Past history of cancer: | |
| Relevant family history of cancer: | |
| Safeguarding concerns: | |
| Other relevant information about patient’s circumstances: | |
| Patient referred/previously investigated for similar symptoms at other hospital/service?  No  Yes, please give details: | |
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| I have discussed the **possible diagnosis of cancer** with the patient/ guardian | |
| I have advised the patient/guardian to **prioritise this appointment & confirmed available within the next 14 days** | |
| The patient/ guardian has been advised that the hospital **may contact them by telephone** | |
| Patient added to the practice **safety-netting system** | |
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| 1. **REFERRER DETAILS** | |
| Usual GP name: | Referring clinician: |
| Practice code: | Practice address: |
| Practice name: | Email: |
| Main Tel: | Practice bypass number       ***(manual entry)*** |
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| 1. **PATIENT DETAILS** | |
| Surname: | First name: |
| NHS number: | Title: |
| Gender on NHS record: | Gender Identity:       ***(manual entry)*** |
| Ethnicity: | |
| DOB: | Age: «PATIENT\_Age» |
| Patient address: | |
| Daytime contact Tel:       **Home:**      **Mobile**: | |
| Email: | |
|  | |
| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |
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| 1. **CONSULATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS** | |
| ***Please note: You will need to add pending test results, requests and relevant excluded medical history (e.g. trans history, sexual health, private patients) manually in the text boxes below.*** | |
| Consultations: | |
| Medical history: | |
| Medication: | |
| Allergies: | |
| Imaging studies (in the past 6 months): Date:        Location: | |
| Renal function (in the past 6 months): | |
| Full blood count (in the past 6 months): | |
| Erythrocyte Sedimentation Rate (ESR) (in the past 6 months): | |
| C-reactive protein test (in the past 6 months): | |
| Test results pending (type of investigation) :       Trust / Organisation:       Date: | |
| All Values and Investigations (in the past 6 months): | |
| BMI (latest): | |
| Weight (latest): | |
| Blood Pressure (latest): | |
| Safeguarding history: | |
| Learning disability: | |
| Use of wheelchair: | |
| Accessible Information Needs (AIS): | |