**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 DOBNHS NumberReferral DateLocal 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**
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| ***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**
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| **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**
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| 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**
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| 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**
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| 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:       |
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| **Carer/ key worker details:** |
| Name:         | Contact Tel:        |
| Relationship to patient:       |  |
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| 1. **CONSULATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS**
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| ***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):       |