**BNSSG Suspected head and neck Cancer Referral Form**

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

**DENTISTS – please email referral to** [***FastTrackOffice@uhbw.nhs.uk***](mailto:FastTrackOffice@uhbw.nhs.uk)

Please ensure all fields are completed, this will help ensure the patient is seen in the most appropriate clinic and in a timely way. Requesting additional information can delay appointments.

|  |  |  |
| --- | --- | --- |
| Referral date: **Short date letter merged** |  | |
| 1. **REFERRER DETAILS – ESSENTIAL** | | |
| Usual GP name: **Free Text Prompt** | | Referring clinician: **Free Text Prompt** |
| Practice code: | | Practice address: **Organisation Full Address (stacked)** |
| Practice name: | | Email: **Organisation E-mail Address** |
| Main Tel: **Organisation Telephone Number** | | Practice bypass number       ***(manual entry)*** |

|  |  |
| --- | --- |
| 1. **PATIENT DETAILS – ESSENTIAL** | |
| Surname: **Surname** | First name: **Given Name** |
| NHS number: **NHS Number** | Title: **Title** |
| Gender on NHS record: **Gender(full)** | Gender Identity: **Free Text Prompt** ***(manual entry)*** |
| Ethnicity: | Hospital No.: **Hospital Number** |
| DOB: **Date of Birth** | Age: |
| Patient address: **Home Full Address (stacked)** | |
| Daytime contact Tel:       **Home:** **Patient Home Telephone** **Mobile:** **Patient Mobile Telephone**  *Please check telephone numbers* | |
| Email: | |
| Does the patient have the capacity to consent? Yes  No | |
|  | |
| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |

|  |
| --- |
| 1. **REASON FOR REFERRAL – ESSENTIAL**   [See Remedy Head and Neck Cancer Referral Guidance](https://remedy.bnssg.icb.nhs.uk/urgent-suspected-cancer-usc/head-neck-incl-thyroid-usc-2ww/) |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer.***  ***If referring for a neck lump, please note the duration and whether the lump is persistent in the same location*** |
| 1. **SPECIFIC CRITERIA FOR URGENT REFERRAL – ESSENTIAL** |
| **Criteria for urgent SUSPECTED HEAD AND NECK CANCER – NECK LUMP:** |
| An unexplained palpable lump in the neck i.e. of recent onset or a previously undiagnosed lump that has changed over a period of 3 – 6 weeks.  An unexplained persistent swelling in the parotid or submandibular gland |
| **Criteria for urgent SUSPECTED THYROID CANCER:** |
| Unexplained thyroid lump  Please perform thyroid function test in parallel with referral |
| **Criteria for urgent SUSPECTED HEAD AND NECK CANCER – EAR, NOSE AND THROAT ORIGIN:** |
| Age >40 with constant unexplained hoarseness > 3 weeks, and a negative chest X-ray  Age >40 with an unexplained constant sore throat especially if it is severe, lateralising or associated with dysphagia, hoarseness or otalgia  Unexplained unilateral serous otitis media/ effusion in a patient aged over 18 |
| **Criteria for urgent SUSPECTED HEAD AND NECK CANCER – ORAL MAXILLO-FACIAL ORIGIN**  NICE Guidance Advises; Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either a lump on the lip or in the oral cavity or a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia.  ***If patient doesn’t have access to a dentist please note this here***  ***If possible, please attach images of the area of concern to this referral***  ***- guidance on taking intra-oral photos is available on Remedy*** |
| Unexplained ulceration of the oral cavity or mass persisting for > 3 weeks  Unexplained red and white patches (including suspected lichen planus) of the oral cavity particularly if painful, bleeding or swollen  Oral cavity and lip lesions or persistent symptoms of the oral cavity followed up for six weeks where definitive diagnosis of a benign lesion cannot be made  Non-healing extraction sockets (>4 weeks duration) or suspicious loosening of teeth, where malignancy is suspected (particularly if associated with numbness of the lip) |
| Referral is due to **clinical concerns that do not meet above criteria - please provide full description in Section 1**  Please note: unilateral sensorineural hearing loss is not a symptom of head and neck cancer. Please refer patients with this symptom via the normal channels.  ***If no specific criteria are met,*** *consider seeking Advice and Guidance from a specialist before referring urgently* |
| **Clinical risk factors**  **No risk factors**  Alcohol history  HPV  HIV  Previous irradiation to head and neck  Family history of thyroid cancer  Oral tobacco use  Ex-smoker  Current smoker If yes:       packs per day       years smoked |

|  |  |
| --- | --- |
| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL** | |
| **WHO Performance status** | |
| **0** Fully active  **1** Restricted physically but ambulatory and able to carry out light work  **2** Ambulatory more than 50% of waking hours; able to carry out self-care  **3** Limited self-care; confined to bed or chair more than 50% of waking hours  **4** Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair | |
| **Other access needs** *- Please detail per the selected options in the field below* | |
| **No access needs**  Interpreter required If Yes, Language:  Transport required.  Mobility needs  Wheelchair access required | Cognitive impairment including dementia  Learning disability  Autism  Mental health issues that may impact on engagement  Severe mental illness |
| Details of access needs: | |

|  |
| --- |
| 1. **ADDITIONAL IMPORTANT CLINICAL INFORMATION** |
| 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: |

|  |
| --- |
| I have discussed the **possible diagnosis of cancer** with the patient |
| I have provided the patient the urgent fast track referral leaflet [(Patient Information & Safety Netting)](https://remedy.bnssg.icb.nhs.uk/urgent-suspected-cancer-usc/patient-information-safety-netting/) |
| I have advised the patient to **prioritise this appointment & confirmed they’ll be available within the next 14 days.** |
| The patient has been advised that the hospital care **may contact them by telephone** |
| Patient added to the practice **safety-netting system,** where available |
| Where required, please provide additional information here concerning the above questions e.g. if patients have dates that they are not available: |

|  |
| --- |
| 1. **CONSULTATIONS, 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: **Consultations** |
| Medical history: |
| Medication: **Medication** |
| Allergies: **Allergies** |
| Imaging studies (in the past 12 months): Date:        Location: |
| Thyroid function (in the past 6 months): |
| Full blood count (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): **BMI** |
| Weight (latest): |
| Blood Pressure (latest): |
| Alcohol consumption (units per week) **Alcohol Consumption** |
| Smoking status: **Smoking** |
| Safeguarding history: |

|  |
| --- |
| **Trust Specific Details**  ***Please note:***   * ***North Bristol Trust does not have a Head and Neck cancer service*** |

|  |
| --- |
| ***For hospital to complete*** UBRN:  Received date: |

**Refer to:**

UHB