**Suspected Head and Neck Cancer Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS Number: | |
| Telephone Numbers  **Please check tel nos with patient** | Tel No (Home): | Tel No (work): | Tel No (Mobile): |
| **GDP Details** | | | |
| Referring GDP: | | GDP Tel No: | |
| Practice Name: | | Practice Email Address: | |
| Practice Address: | | Date of decision to refer: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Information** | | | |
| Does your patient have a learning disability? | | | YesNo |
| Is your patient able to give informed consent? | | | YesNo |
| Is your patient fit for day case investigation? | | | YesNo |
| If a translator is required, please specify language: | | | |
| Is patient on any of the following medications? | | | |
| Aspirin | YesNo | Indication for therapy: | |
| Clopidogrel /Prasugrel etc . | Yes No | Indication for therapy: | |
| Warfarin | Yes No | Indication for therapy: | |
| NOAC (Rivaroxaban etc.) | Yes No | Indication for therapy: | |
| Insulin | Yes No |  | |

|  |
| --- |
| It would be helpful if you could provide performance status information (please tick as appropriate)  Fully active  Able to carry out light work  Up & about 50% of waking time  Limited to self-care, confined to bed/chair 50%  No self-care, confined to bed/chair 100% |

|  |
| --- |
| Please confirm that the patient is aware that this is a suspected cancer referral:  Yes  No |
| Date(s) that patient is unable to attend within the next two weeks:  *If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

|  |  |
| --- | --- |
| **Level of Cancer Concern** (completion optional) | |
| **All patients should meet NICE guidelines for suspected cancer 2015**  *“I’m very concerned that my patient has cancer”*  *“I’m unsure, it might well be cancer but there are other equally plausible explanations.”*  *“I don’t think it likely that my patient has cancer but they meet the guidelines.”*  **Reasons for referring**  *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* | |
| **Referral Criteria** | |
| **Suspected Head and Neck Cancer - General:**  An unexplained 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 | **Suspected Thyroid Cancer:**  unexplained thyroid lump (consider)  *It would be very helpful if a thyroid function test result less than 8 weeks old could be provided* |
| **Suspected Head and Neck Cancer – Ear, Nose and Throat Origin:**  Persistent unexplained hoarseness ie >3 weeks, with negative chest X-ray (consider)  An unexplained persistent sore throat especially if associated with dysphagia, hoarseness or otalgia  Referred otalgia as a symptom of laryngeal or pharyngeal malignancy  Dysphagia with obstruction in pharynx of cervical oesophagus  Persistent unilateral nasal obstruction with bloody discharge  Unexplained serous otitis media/ effusion in a patient aged over 18 | **Suspected Head and Neck Cancer – Oral Maxillo-Facial Origin**  Unexplained ulceration of the oral cavity or mass persisting for more than 3 weeks (consider)  Unexplained red and white patches (including suspected lichen planus) of the oral cavity particularly if painful, bleeding or swollen (consider).  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) |
| 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. | |

|  |
| --- |
| **Clinical Summary** |
| **Clinical History (significant past and current medical history):** |
| **Current medication:** |
| **Blood Tests (if available – last 3 months):** |
| **Allergies:** |
| **Smoking:** |
| **BMI** (if available): |
| **Alcohol** (if available)**:** |

**Please send this Suspected Head and Neck Cancer - Oral Maxillo-Facial Origin referral to your nearest provider:-**

**If you are emailing the referral please only use your NHS email account and request a read receipt.**

**Royal Devon & Exeter Hospital Email:** [**rde-tr.opafasttrackteam@nhs.net**](mailto:rde-tr.opafasttrackteam@nhs.net) **No Fax available**

**North Devon District Hospital Email:** [**ndht.cancerbookings@nhs.net**](mailto:ndht.cancerbookings@nhs.net) **No Fax available**

**Derriford Hospital** **Email:** [**plh-tr.RK9Cancer2WW@nhs.net**](mailto:plh-tr.RK9Cancer2WW@nhs.net) **Fax: 01752 430912**

**Torbay Hospital Email:** [**tsdft.headandneck2ww@nhs.net**](mailto:tsdft.headandneck2ww@nhs.net) **No Fax available**

|  |
| --- |
| **For Hospital to complete: NHS No: Received Date:** |