**Suspected Oral & Maxillo-Facial Cancer Referral Form**

(Use different form for ENT Suspected Cancer – please note that referral to incorrect service will cause delays in patient pathway)

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| **GP or GDP Details** | **Patient Details** | | |
| Name: | Name: | | |
| Address: | Address: | | |
| Tel No.: | Tel No. (home): | | *Please check tel. nos* |
| Email: | Tel No. (work): | |
| Decision to Refer Date: | Tel No. (mobile): | |
|  | NHS No.: | DoB: | |
| Hospital No.: | Gender: | |
| Translator Required:  Language: | Mobility: | | |
| Performance Status (WHO)  0 - Able to carry out all normal activities without restriction  1 - Restricted in physically strenuous activity but able to walk and do light work  2 - Able to walk and capable of all self care.. Up and about more than 50% of waking hours  3 - Capable of only limited self care, confined to bed or chair more than 50% of waking hours  4 - Completely disabled. Can not carry out any self care. Totally confined to bed or chair | | | |
| Please confirm that the patient is aware that this is a suspected cancer referral: - Yes  No | | | |
| Please confirm that the patient is available over the next 2 weeks and willing to accept an appointment  Yes  No  *If patient is not available for the next 2 weeks, and aware of nature of referral, please only refer when able and willing to accept an appointment.* | | | |
| **Please tick if you have seen this patient in your surgery prior to making this cancer referral**  Patients should ideally be physically examined prior to an Oral & Maxilo-Facial cancer referral to allow for assessment of the lesion or lump. | | | |

# Referral criteria

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| **Oral cancer**  Oral cancer referrals are booked for outpatient clinic review with a Maxillofacial Consultant.  unexplained ulceration in the oral cavity lasting for more than 3 weeks, **or**  a lump on the lip or in the oral cavity consistent with oral cancer **or**  a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia |

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| **Clinical History:** |
| **Clinical Examination:** |

**Please attach additional clinical details to include:**

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| --- | --- |
| Significant medical history |  |
| Co-morbidities |  |
| Current medication |  |
| Any other relevant information inc allergies |  |

**Attachments:** Letter  Medication List  Other

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| **Additional Information:**  All Isle of Scilly patients may be given a telephone assessment prior to any attendances for diagnostics.  Macmillan rapid referral guidelines:  <http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PCCL/Rapidreferralguidelines.pdf>  Suspected cancer: recognition and referral June 2015 NICE guidance: <http://www.nice.org.uk/guidance/ng12> |