**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>  |