**ADULT SUSPECTED HEAD AND NECK CANCER REFERRAL FORM**

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| **Hospital selection** | |
| Somerset Foundation Trust/Musgrove Park | ☐ |
| Yeovil District | ☐ |
| **Please ensure all mandatory 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.** | |

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| **Patient details** | | | |
| **Forename** |  | **Address** |  |
| **Surname** |  |
| **DOB** |  | **NHS No.** |  |
| **Hospital No.** |  |
| **Home tel number** |  | **Gender** |  |
| **Mobile tel number** |  | **Ethnicity** |  |
| **Email address** |  | **Date of decision to refer** |  |

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| **Registered GP details** | | | |
| **Practice name** |  | **Tel number** |  |
| **Bypass number** |  |
| **Referring GP** |  | **Email** |  |
| **GP address** |  | **Practice code** |  |

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| **Patient engagement** | | **Yes** | **No** |
| **The patient has been made aware that this is a suspected cancer referral** | | **☐** | **☐** |
| **The patient has received the suspected cancer referral leaflet** | | **☐** | **☐** |
| **The patient has been informed that they may be contacted by secondary care to undergo tests before the appointment** | | **☐** | **☐** |
| **Has any other suspected cancer referrals been made for the patient?** | | **☐** | **☐** |
| **If yes, please provide details:** | |  | |
| **The patient is available to attend the appointment/tests in the next 14 days** | | **☐** | **☐** |
| **Has the patient had a physical examination?** | | **☐** | **☐** |
| **Days the patient is not available:** |  | | |
| **If your patient is found to have a cancer, do you have any information which might be useful for secondary care regarding their likely reaction to the diagnosis (e.g. a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological or emotional readiness for further investigation and treatment?** |  | | |

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| **Referral criteria** | | |
| **Please note: unilateral sensorineural hearing loss and / or tinnitus is not a symptom of head and neck cancer. Please refer patients with these symptoms via the normal channels.** | | |
| **General**  ***(likely US +/- FNA first appointment)*** | 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)  ***(particularly if the lump is palpable (not just a feeling of a lump), and the lump is persistent or increasing in size)*** | ☐ |
| An unexplained persistent swelling in the parotid or submandibular gland | ☐ |
| **Thyroid cancer**  ***(likely US +/- FNA first appointment)***  ***Please also request TFTs alongside this referral*** | Thyroid swelling associated with:  ☐ Solitary nodule, typically hard increasing in size  ☐ Unexplained hoarseness or voice change associated with goitre  ☐ Symptoms of tracheal compression  ☐ Enlarged cervical nodules  ☐ Family history of endocrine tumour  ☐ History of neck irradiation  ☐ Pre-pubertal patients  ☐ Aged ≥ 65yrs | ☐ |
| **Laryngeal cancer**  **(ENT)** | Persistent unexplained hoarseness of voice  ***(particularly if ≥ 45yrs, no precipitating respiratory infections, and a normal chest x-ray)*** | ☐ |
| **Pharyngeal cancer**  **(ENT)** | Visible pharyngeal/tonsillar mass | ☐ |
| Persistent and unexplained sore throat for >6 weeks | ☐ |
| Unilateral sore throat (especially if associated with dysphagia, hoarseness or otalgia) | ☐ |
| Unilateral pain radiating to the ear (referred otalgia) with normal otoscopy | ☐ |
| Pain on swallowing (odynophagia) | ☐ |
| Difficulty in swallowing/obstruction (dysphagia) | ☐ |
| **Oral cancer**  **(Max-Fax)** | Unexplained ulceration in the oral cavity lasting ≥ 3 weeks | ☐ |
| Lump on lip or mass in the oral cavity and persisting for more than 3 weeks | ☐ |
| Red or white patch in oral cavity consistent with erythroplakia or erythroleukoplakia | ☐ |
| Non-healing extraction sockets (>4 weeks duration) or suspicious loosening of teeth, where malignancy is suspected (particularly if associated with numbness of the lip) | ☐ |
| **Other**  **(ENT)** | Persistent unilateral nasal obstruction with bloody discharge | ☐ |
| Aged ≥ 18yrs and unexplained unilateral serous otitis media/effusion | ☐ |
| Orbital masses | ☐ |
| Unexplained persistent cranial neuropathies | ☐ |
| **Level of concern**  **I think it is likely that this patient has cancer and would like the patient to be investigated further. Please include the details below in the referral letter section.**  **(Cases that fall short of the suspected cancer referral criteria should be discussed)** | | ☐ |

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| **Referral letter**  **(please include any symptoms and examination findings)** |
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| **Additional clinical information** | | |
| **Past history of cancer** |  | |
| **Family history** |  | |
| **Smoking status** |  | |
| **Alcohol intake** |  | |
| **Is the patient currently on any anticoagulants?** | ☐ Yes ☐ No |  |
| **Is the patient currently on any antiplatelet medications?** | ☐ Yes ☐ No |  |
| **Latest BP** |  | |
| **Latest height** |  | |
| **Latest weight** |  | |
| **Latest BMI** |  | |

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| **Relevant investigations**  **(within last 12 weeks)** | | |
| **If available:** | | **Requested today** |
| **FBC** |  | ☐ |
| **U&E (inc. eGFR)** |  | ☐ |
| **TFTs (inc. T4 and TSH)** |  | ☐ |
| **Clotting** |  | ☐ |
| **LFTs** |  | ☐ |
| **CRP** |  | ☐ |
| **Bone profile** |  | ☐ |
| **Iron studies** |  | ☐ |
| **Glucose** |  | ☐ |
| **Imaging** |  | ☐ |

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| **Performance status - WHO classification** | |
| **0 - Able to carry out all normal activity 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, but unable to carry out any work. 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. Cannot carry on any self-care. Totally confined to bed or chair** | **☐** |

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| **Health inequalities information** | | | |
| **Patient agrees to telephone message being left?** | ☐ Yes ☐ No | **Physical disabilities** |  |
| **Learning difficulties** | ☐ Yes ☐ No | **Learning disabilities** |  |
| **Interpreter required** | ☐ Yes ☐ No | **Language required** |  |
| **Language/hearing difficulties** | ☐ Yes ☐ No | **Severe anxiety** |  |
| **Known safeguarding concerns** | ☐ Yes ☐ No | **Patient able to give consent** | ☐ Yes ☐ No |
| **Mobility requirements (unable to climb on/off bed)** | ☐ Yes ☐ No | **Mental capacity assessment required** | ☐ Yes ☐ No |
| **Is your patient fit for day case investigation?** | ☐ Yes ☐ No | **Reason NOT fit for day case** |  |

**Consultations**

**Past Medical History**

**Current Medications**

**Allergies**

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| **For hospitals to complete** | |
| **UBRN** |  |
| **Received date** |  |