**URGENT REFERRAL FORM FOR**

**SUSPECTED HEAD & NECK CANCERS**

(Including Laryngeal, Oral and Thyroid)

***PLEASE USE THE ELECTRONIC E-REFERRAL SYSTEM TO DIRECTLY BOOK APPOINTMENT – THE PROFORMA NEEDS TO BE ATTACHED TO THE UBRN WITHIN 24 HOURS***

Telephone Contact No. for Booking Queries: 0151 604 7720

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| **PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD** | | | | |
| 1. **Has the patient been counselled regarding this referral as per the NICE guidelines i.e. advised why they have been referred to a cancer service and offered appropriate information including where to seek additional support?**   **If no, please explain why:** | | | | Yes ☐ No ☐ |
| 1. **Has the patient been advised that they need to be available within the next four weeks?**   **If no, please explain the reason why:** | | | | Yes ☐ No ☐ |
| **3.** **Have you ensured that the telephone contact details are correct?** | | | | Yes ☐ No ☐ |
| **REFERRER’S DETAILS** | | | | |
| **Referring GP** |  | | **GP Code:** | |
| **Registered GP** |  | | | |
| **GP Address & postcode** |  | | | |
| **GP Tel. No.** |  | | | |
| **GP Fax. No.** |  | | | |
| **Date seen by GP:** |  | **Decision to refer date:** | | |
| **PATIENT DETAILS** | | | | |
| **Title & Surname** |  | **Forename(s)** | | |
| **D.O.B.** |  | **AGE:** | **Gender:** Male**☐** Female**☐** | |
| **Address** |  | | | |
| **Postcode** |  | **\*Tel. No. (day)** | **Mobile Tel.** | |
| **\*Tel. No. (evening)** |  | **NHS No.** |  | |
| **CULTURAL, MOBILITY, IMPAIRMENT ISSUES** | | | | |
| What is the patient’s preferred first language? ………………………………………………..  Does the patient require Translation or Interpretation Services? YES ☐ NO ☐ ………………………………………  Please list any hearing or visual impairments requiring specialist help (Sign language, Braille, Loop Induction systems) ………………………………………………………………………………………………………  Is Disabled Access Required? YES ☐ NO ☐ Is transport required? YES ☐ NO ☐ ………………………  Ethnic Origin: ……………………………………….. Religion: ………………………………………………………  Is the patient from overseas? YES ☐ NO ☐ Is the patient a temporary visitor? YES ☐ NO ☐ | | | | |

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| **REFERRAL INFORMATION** |
| **Cancer type suspected:**  **Oral Cavity**  ☐ **FOR THE ORAL AND MAXILLO-FACIAL DEPARTMENT**    **Larynx** ☐  **Pharynx**  ☐  **FOR THE EAR, NOSE AND THROAT DEPARTMENT**  **Neck Lump**  ☐  **Thyroid** ☐ |
| **Symptoms:**  Persistent hoarseness > 6 weeks Yes ☐ No ☐  Unexplained lump in the neck Yes ☐ No ☐  Persistent swelling of parotid/submandibular gland Yes ☐ No ☐  Unexplained pain on swallowing > 3 weeks Yes ☐ No ☐  Unexplained ulceration of oral cavity > 3weeks Yes ☐ No ☐  Red or white patches in oral cavity Yes ☐ No ☐  *Thyroid swelling associated with any of the following:*  Rapid increase in size of solitary nodule Yes ☐ No ☐  Family history of thyroid cancer Yes ☐ No ☐  History of neck irradiation Yes ☐ No ☐  Unexplained hoarseness Yes ☐ No ☐  Very young age (under 16 years) Yes ☐ No ☐ |
| Discussion with a specialist (for example, by telephone or email) should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical **[2015].** |
| **This is a free text box to facilitate any additional information which might not be in the main clinical record with regards to why you feel this patient may have cancer.** |
| **Please use this area during formatting on IT systems to upload a brief patient summary which should/may include:** recent consultations, current diagnosis; past medical history; recent investigations; medication; any other fields which might be helpful to aid triage in secondary care. |