**URGENT REFERRAL FORM FOR**

**SUSPECTED BRAIN & CENTRAL NERVOUS SYSTEM CANCERS- ADULTS**

To make an **URGENT REFERRAL**

Fax: 0151 529 5769

Telephone Contact No:  Neurology Consultant Advice Line - 07860 481429 or Walton Switchboard 0151 525 3611 and ask for on call Neurosurgery Registrar

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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 two weeks and for any subsequent appointments?**   **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**  **Please use the free text box to describe any significant features to support this referral and assist the receiving team**  **Confirm the patient has progressive, sub-acute (i.e days-weeks) loss of central neurological function**    **Additional information:**  **Previous history of cancer**  **Neurological deficit (describe)**  **Papilloedema**  **Early morning headache (headaches that wake the patient from sleep)**  **New onset seizures**  **Performance Measures/score:**  0: able to carry out all normal activity without restriction  1: restricted in strenuous activity but ambulatory and able to carry out light work  2: ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours  3: symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden  4: completely disabled; cannot carry out any self-care; totally confined to bed or chair. |
| For patients who have a positive scan   * Please attach a copy of the MRI report or CT report attached **☐** |
| **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. |