|  |  |  |  |
| --- | --- | --- | --- |
| Text  Description automatically generated | | **HEAD & NECK**  ***Urgent Suspected Cancer (USC) referral***  ***Please refer via e-Referral Service*** | |
| **Please use separate children’s proforma for patients under 16** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | | |
| **Patient Name** | ${firstname} ${surname} | | |
| **Address** | ${patientAddress}  ${postcode} | | |
| **DOB** | ${dob} | **NHS No.** | ${nhsNumber} |
| **Home Tel. No.** | ${home} | **Gender** | ${gender} |
| **Mobile Tel. No.** | ${mobile} | **Ethnicity** | ${ethnicity} |
| **Preferred Tel. No.** | ${preferredNumber} | **Email Address** | ${email} |
| **Main Spoken Language** | ${language} | **Interpreter needed?** | Yes  No |
| **Transport needed?** | ${transportNeeded} | **Patient agrees to telephone message being left?** | Yes  No |
| **Communication requirements** | Hard of hearing:  Visually impaired:  Learning/mental difficulties:  Dementia:  Communication difficulties other: (please specify)  ${communicationDifficultiesOther} | | |
| **Photograph attached (where available – not mandatory)** | Photo included  Consent obtained for Imaging (If Photograph included) | | |
| **Patient has device which accepts video calling?** | Yes  No | | |
| **Date of Decision to Refer** | ${createdDate} | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Registered GP Details** | | | |
| **Practice Name** | ${practiceName} | | |
| **Registered GP** | ${usualName} | **Usual GP / Referring GP** | ${referringClinical} |
| **Registered GP**  **Address** | ${practiceAddress} | | |
| **Tel No.** | ${main} | **Fax No.** | ${fax} |
| **Email** | ${gpEmail} | **Practice Code** | ${practiceCode} |

|  |  |  |  |
| --- | --- | --- | --- |
| **Registered Dentist Details** | | | |
| **Patient registered with a dentist** | Yes  No | | |
| **Practice Name** | ${dentistPracticeName} | | |
| **Registered / Usual dentist** | ${usualDentist} | **Referring dentist** | ${referringDentist} |
| **Practice address** | ${dentistAddress} | | |
| **Tel No.** | ${dentistTel} | **Email** | ${dentistEmail} |

|  |  |
| --- | --- |
| **Patient Engagement** | |
| **The patient has been informed that the reason for referral is to rule out or rule in Cancer.** |  |
| **Supporting information (USC leaflet) provided** |  |
| **The patient has been informed of the likely next pathway steps and the time in which they should be contacted?** |  |
| **The patient has confirmed that they are willing and available to be contacted and attend the hospital for appointments and tests within the required timeframes?**  **(and that this may include virtual or telephone consultations if appropriate)** |  |
| **Does the patient want a relative present at the appointment** | Yes  No |
| **Patient or Carer Concerns/ Support Needs at the point of referral:** | |
| ${carerConcernsOrSupportNeeds} | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Emergency**  **(Contact Consultant and admit)** | **Yes** | **USC** | **Yes** | **Consider urgent referral for assessment by a General Dental Practitioner:** | **Yes** |
| **Thyroid** |  |  | Thyroid mass associated with unexplained hoarseness or voice change, cervical lymphadenopathy or rapid enlargement over a period of week |  |  |  |
| **Head and Neck Cancer**  **ENT** | Stridor |  | Lump or ulceration in tonsil/orophrarynx  Persistent and unexplained neck lump |  |  |  |
| Persistent unexplained hoarseness >45 years |  |
| **Head and Neck Cancer**  **Maxilo-Facial Surgery** |  |  | Persistent and unexplained neck lump |  | **Unexplained:** |  |
| A lump or lesion of oral cavity (lip/teeth/gums/palate/tongue/floor of mouth/mucosa, NOT Tonsil) |  | Lump on lip or oral cavity that has not been assessed by a dental surgeon |  |
| Unexplained ulceration in oral cavity lasting >21d |  | Red or white patch in the oral cavity consistent with erythroplakia or Erythroleukoplakia |  |
| **If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.** | | | | | |  |

|  |  |
| --- | --- |
| **Risk factors** | |
| **Thyroid** | Over 55 yrs  Previous neck irradiation  Family history of endocrine tumours  Family history of thyroid tumours |
| **Head and neck** | Alcohol  Smoking |

|  |
| --- |
| **Please add clinical details and examination findings**  **(this can be copied from your consultation note)** |
| ${symptomsAndExaminationFindings} |

|  |  |
| --- | --- |
| **Additional clinical information** | |
| **Family history** | ${relevantFamilyHistoryOfCancer} |
| **Smoking history** | ${smoking} |
| **Alcohol intake** | ${alcoholConsumption} |
| **Latest BP** | ${latestBP} |
| **Latest height** | ${lastHeight} |
| **Latest weight** | ${lastWeight} |
| **Latest BMI** | ${lastBMI} |

|  |  |
| --- | --- |
| **Relevant investigations** | |
| **All patients requiring a 'suspicious of cancer' referral must have a recent (< 3 months) U&E result to facilitate efficient pathway next steps.** | |
| **U&E** | ${renalFunctionG} |
| **Other** | ${relevantInvestigations} |

|  |  |
| --- | --- |
| **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** |  |

**Consultations**

${additionalClinicalInfo}

**Past Medical History**

${medicalHistory}

**Family history**

${relevantFamilyHistoryOfCancer}

**Current Medications**

${medication}

**Allergies**

${allergies}

|  |  |
| --- | --- |
| **To be completed by the Hospital Data Team** | |
| **Date of decision to refer** |  |
| **Date of appointment** |  |
| **Date of earliest offered appointment (if different to above)** |  |
| **Specify reason if not seen at earliest offered appointment** |  |
| **Periods of unavailability** |  |
| **Booking number (UBRN)** |  |
| **Final diagnosis: Malignant**  **Benign** | |