1. 2ww Referral to Head and Neck

Mr. Michael Nussbaumer
ENT Consultant

Paragraph Styles

2WW Referral for Head and Neck (adult)

Date of GP decision to refer: __ /__ /

Thyroid Cancer

2WW referral for unexplained thyroid lump ☐

Thyroid Cancer – risk factors (tick if applies)

Over 55yrs. with a neck lump ☐
Previous neck irradiation ☐
FH of endocrine tumours ☐
FH of thyroid tumours ☐

Thyroid lump – additional features (tick if applies)

Stridor associated with thyroid lump ☐ → (This is an Emergency – please contact Mr Wickham (H+N Consultant) on Tel: 07885 650949 OR the on-call ENT team at BHNFT)

Thyroid lump rapidly enlarging over 2-4 weeks ☐
Unexplained hoarseness or voice change with thyroid lump ☐
Cervical lymphadenopathy with a thyroid lump ☐
New thyroid lump in those aged 55 yrs. and over ☐

Laryngeal Cancer

2WW referral for patients 45 years old and over with either:

Persistent unexplained hoarseness ☐ OR Unexplained lump in the neck ☐

Oral cancer

Persistent unexplained hoarseness ☐ OR Unexplained lump in the neck ☐

Oral cancer

2WW referral for patients with any of the following:

Unexplained ulceration in oral cavity lasting for more than 3 weeks ☐

Persistent unexplained lump in the neck ☐

Unexplained lump on the lip or in the oral cavity ☐

A red or red/white persistent patch in the oral cavity ☐

Oral cancer – additional features (tick if applies)

A red or white patch on the oral mucosa +/- pain, bleeding or swelling ☐

Ulcer or mass on oral mucosa for more than 3 weeks ☐

Unexplained tooth mobility for more than 3 weeks ☐

Sensory loss – lip or tongue ☐

Head and Neck cancer – additional 2ww referral reasons

Stridor and increasing dysphagia ☐ Increasing Dysphagia ☐ Otalgia ☐

Persistent swelling of submandibular or parotid gland ☐ Persistent painful sore throat especially if unilateral ☐

Unilateral nasal obstruction and discharge ☐ Unilateral nasal discharge in people aged over 50 yrs. ☐

Unilateral otitis media with effusion in people aged over 50 yrs. ☐ Orbital masses ☐

Head and Neck Cancer – risk factors (tick if applies)

45 yrs. or older ☐

Unintentional weight loss (> 3kg in 6 weeks) ☐

Previous surgery (Head, neck, mouth) ☐

2.Breast Clinic Referrals

Ms J Dicks
Oncoplastic Breast Surgeon
Barnsley Hospital

Breast clinics

- Urgent 2 week referral
- Symptomatic 2 week referral
- Family history clinic
- Reconstruction clinic
- Self referral to Breast screening over 70 years

Urgent 2 week referral

- **Aged 30 and over and unexplained breast lump**
- **Aged 50 and over with any unilateral nipple changes of concern including discharge or retraction**
- **Skin changes suggestive of cancer**
- **Aged 30 or over and unexplained lump in axilla**
- **Previous breast cancer presenting with further lumps or suspicious symptoms who is no longer under review**

Symptomatic 2 week referral

- All other breast problems!
- Don’t need U+Es
- Young women (under 25y) could be re-examined after their next period

Family history clinic

- Not suitable if any symptoms

Reconstruction clinic

- Patients considering reconstruction or breast reduction
- Patients who have had previous reconstruction and have cosmetic concerns
- Not suitable if any symptoms

The criteria are compliant with 2015 NICE guidelines for referring those with suspected cancer and not a substitute for your own clinical judgement or taking specialist professional advice as appropriate.

*Performance Status (Adult) A WHO classification indicating a PERSON's status relating to activity/disability.

		Please Tick
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	

- **Consider referral to symptomatic breast clinic if outside the below criteria – these patients will still be seen within 2 weeks.**
- **Asymptomatic patients presenting with a Family History of Breast Cancer should be referred directly to the Breast Family History Clinic at BHNFT.**

Referral Criteria

2 WW referral should be made, male or female, if:

- Aged 30 and over and unexplained breast lump [with or without pain] ☐
- Aged 50 and over with any unilateral nipple changes of concern including discharge or retraction ☐
- Skin changes suggestive of cancer ☐
- Aged 30 or over with unexplained lump in axilla ☐
- Previous breast cancer presenting with further lumps or suspicious symptoms who is no longer under review ☐

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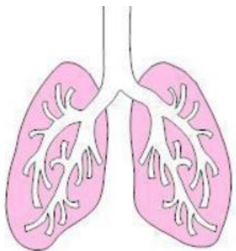
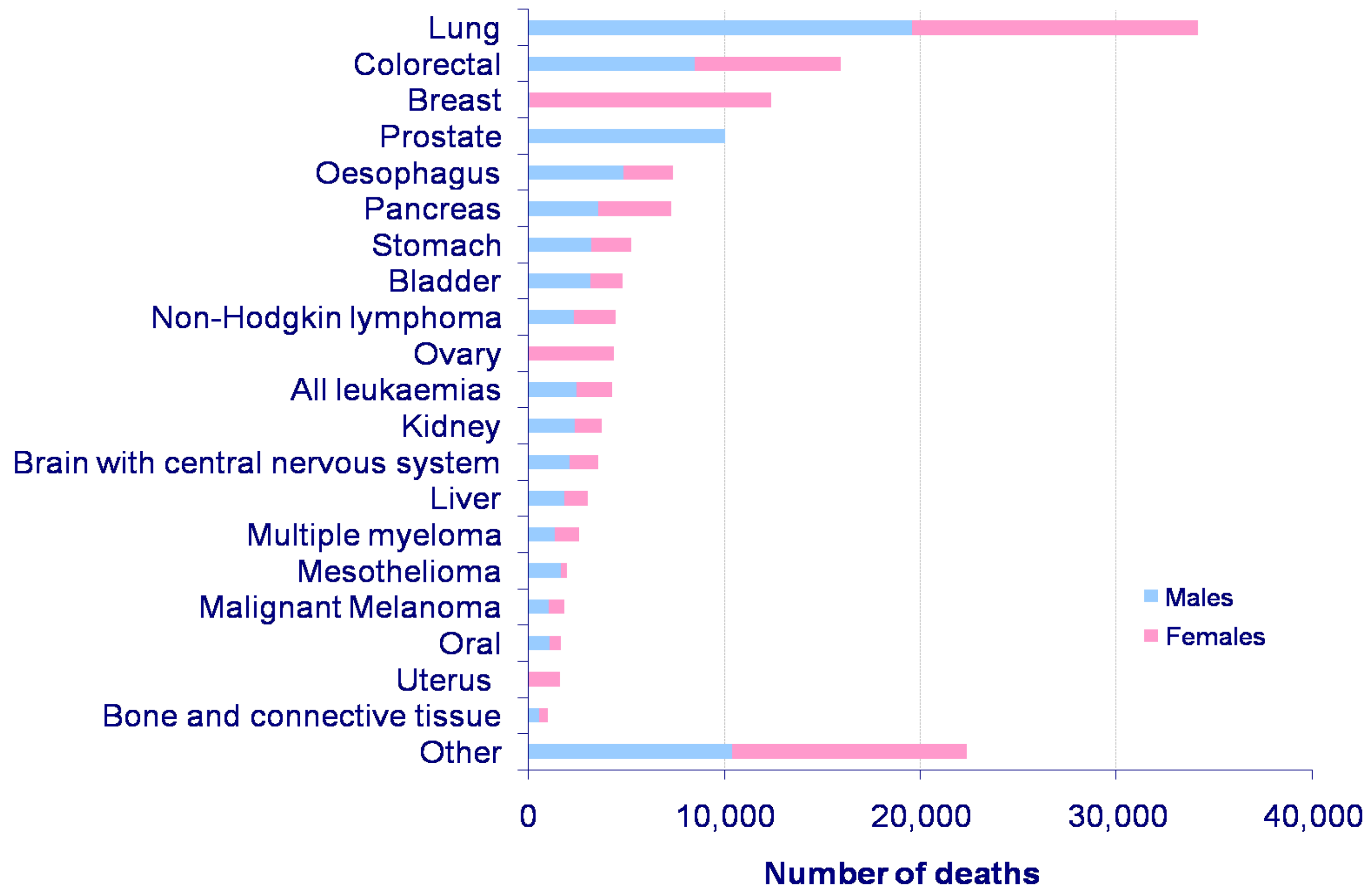
NHS Foundation Trust

Barnsley Lung Cancer Pathway

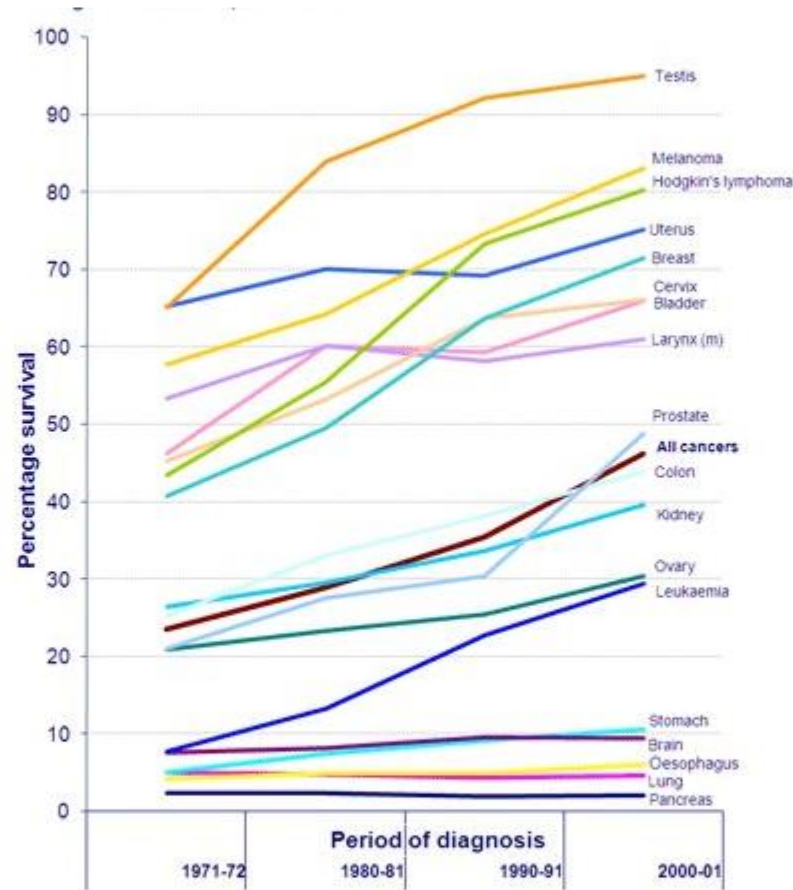
Dr M Jamil Malik Respiratory Consultant
Lung cancer-EBUS/Thoracoscopy lead.



The 20 most common causes of death from cancer, UK, 2006



Ten year relative survival of adults dignosed with cancer in England & Wales,1971-2001



When to suspect lung cancer ?

- Mainly based on symptoms
- Signs sometimes present
- Lower threshold in smokers/ COPD patients
- Above 40 years of age

Urgent referral for a chest x-ray should be made when a patient presents with:

- Haemoptysis

Or unexplained or persistent (more than 3 weeks)

- Cough
- Chest/shoulder pain
- Dyspnoea
- Weight loss
- Chest signs
- Hoarseness
- Finger clubbing
- Features suggestive of metastasis from a lung cancer
- Persistent cervical/supraclavicular lymphadenopathy

Overview of care pathway

Barnsley Hospital NHS
NHS Foundation Trust

Symptoms and signs indicating urgent referral (page 8)

Symptoms and signs indicating urgent chest X-ray (page 8)

Chest X-ray

Chest X-ray normal?

Yes → Low suspicion of lung cancer

No

Urgent referral to lung cancer MDT (usually chest physician)

Information and support (page 7)

Clinical examination, fitness assessment and CT scan of thorax, upper abdomen and lower neck

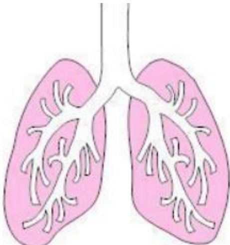
Further diagnostic tests to stage the disease and guide treatment (see pages 8–11)

Treatment with curative intent (see page 13)

Active supportive care and palliative treatment (see pages 16 and 17)

Consider adjuvant chemotherapy (see page 14)

Follow-up (see page 17)



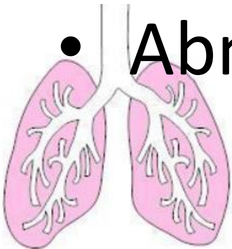
Lung Cancer Guideline NICE 2011

Barnsley Hospital NHS
NHS Foundation Trust

Referral Routes

A&E	Acute medical admissions	GP

- Weekly Mond,Tues and wed pm clinic 13 new patient slots (electronic choose & book)
- 2 CT slots weekly but trying to get CT before seeing pt or same day but need up-to-date U/Es,FBC before CT
- Abnormal CXR –CT through radiology/?GP



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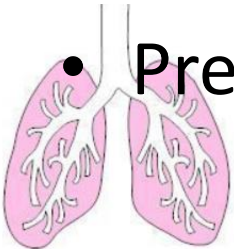
First Clinic Visit

- Lung cancer clinical nurse specialist available
- Lung cancer proforma
- Spirometry
- Imaging – CXR/CT
- Thoracic USS diagnostic pleural aspirate
- Further investigations arranged as appropriate
- Bronchoscopy Mon & Thur am
- Pre – Lung MDTM Fri/Mon, Lung MDTM Tues am



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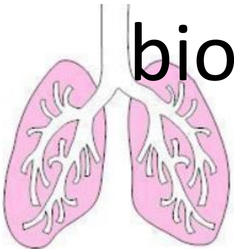
Further Investigations

- Locally EBUS TBNA, mini – probe for peripheral lesions & medical thorocoscopy weekly
- Locally CT & USS guided biopsies
- Regional CT-PET service NGH
- Regional cardiothoracic mediastinoscopy, surgical thorocoscopy, surgical biospy/resection



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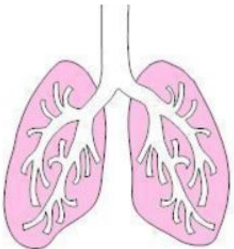
Case History

- 63 yr old male
- PMH chronic asthma – becotide, ventolin
- PC chronic intermittent cough, minimal haemoptysis, intentional weight loss
- PS 0
- Ex-smoker 25 pack yrs, no asbestos exposure
- OE chest clear, no clubbing



PA ERECT

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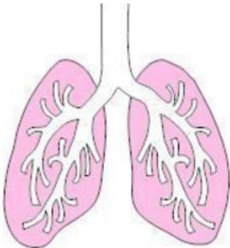

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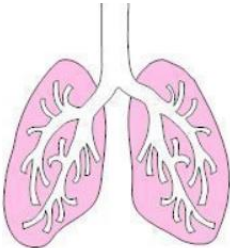
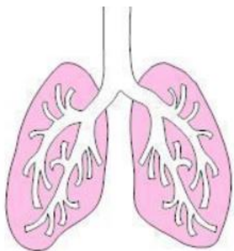


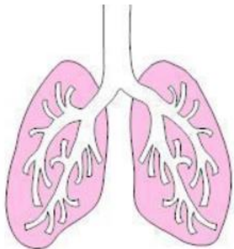
Further Investigations – first visit

- CXR – L basal atelectasis, soft tissue density over cardiac silhouette
- FEV1 1.14 (40%), FVC 2.72 (70%)
- Staging CT – 3 x 3.5cm mass medial basal segment LLL, nodule LUL T2a/4 (LUL nodule), N0/X, M0



Further Investigations – first visit

- Asthma treatment maximised
- PET-CT arranged & bronchoscopy booked
- Patient made aware of likely diagnosis
- Lung MDTM discussion



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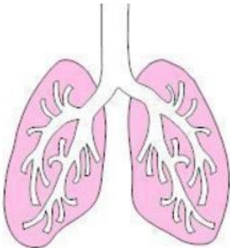
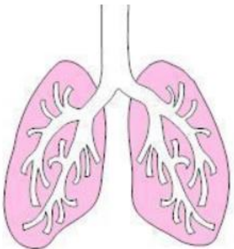
MIRADA
medical



Outcome

- PET-CT T2b, ?N2, M0
- Bronchoscopy – squamous cell lung cancer
- Radical curative treatment – cardiothoracic surgery



DR M JAMIL MALIK, RESPIRITORY
CONSULTANT, LEAD IN LUNG CANCER,
THORACOSCOPY AND EBUS, BARNSLEY,
NHS FOUNDATION TRUST

Referral Criteria

2WW referral criteria:

- CXR suggests possible cancer ☐
- 40 or over with unexplained haemoptysis ☐
- **Normal CXR but significant ongoing clinical concerns** ☐

Urgent CXR [within 2 weeks] if:

- Persistent or recurrent chest infection ☐
- Finger clubbing ☐
- Supraclavicular lymphadenopathy or persistent cervical Lymphadenopathy ☐
- Thrombocytosis ☐
- If chest signs compatible with pleural disease ☐

Consider urgent CXR [within 2 weeks] if:

- 40 or over, never smoked, but 2 or more of the following: ☐

OR

- 40 or over and previously smoked, with 1 or more of the following: ☐

OR

- Any age with asbestos exposure and 1 or more of the following: ☐

Cough ☐ Fatigue ☐ Shortness of breath ☐ Chest pain ☐ Shoulder pain ☐ Weight Loss ☐ Appetite Loss ☐

2WW LUNG URGENT SUSPECTED CANCER REFERRAL FORM (adult)

Date of GP decision to refer: __ /__ /

Symptoms and Signs

Investigations required for referral within the last month: but do not delay referral

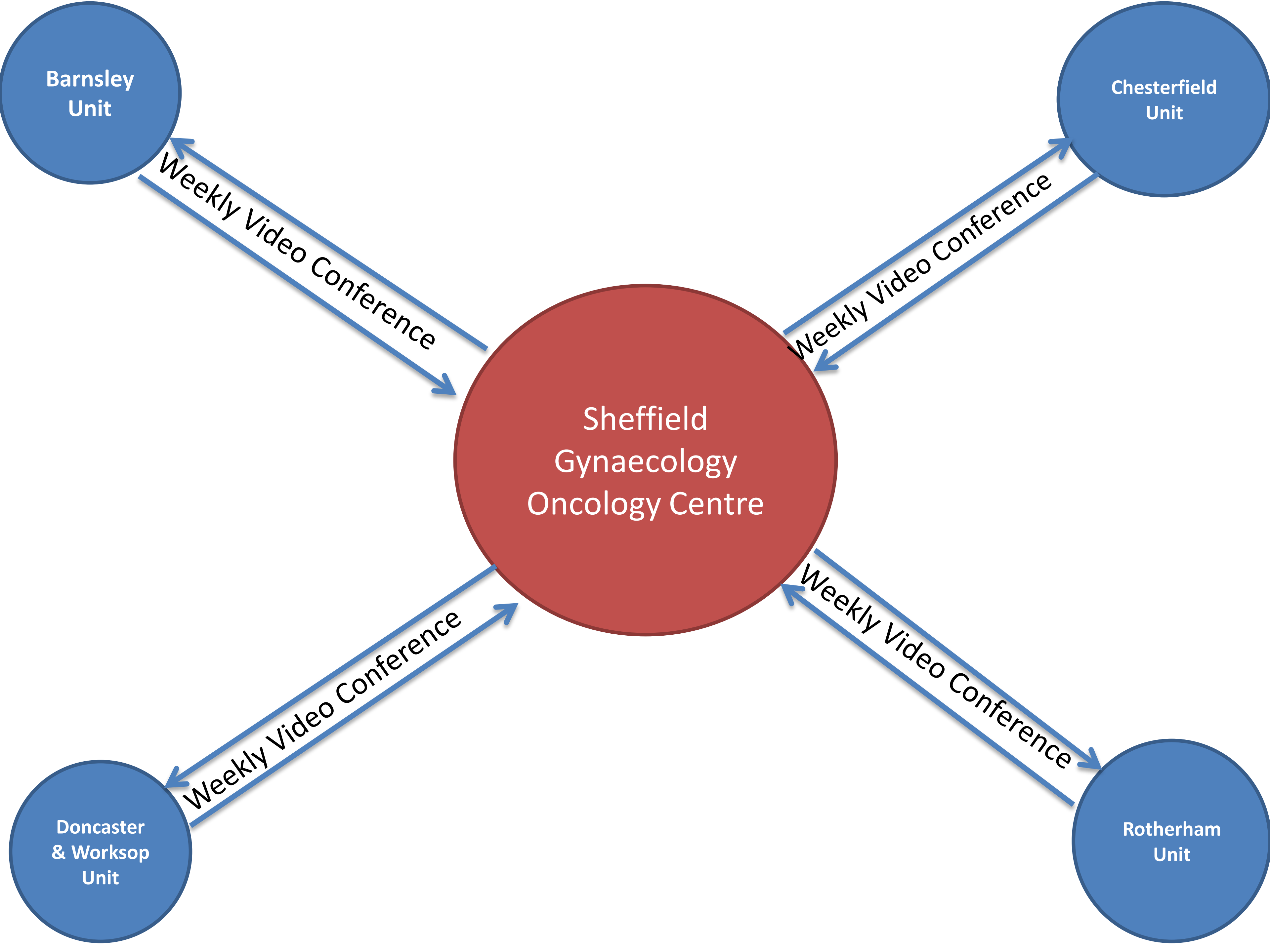
Bloods (essential)

- U + E ☐
- FBC ☐
- Coagulation screen ☐
- LFTs ☐

4.
2ww Gynaecology Cancer Referral

Mr. Khaled Farag

Consultant Obstetrician and Gynaecologist


Barnsley Unit
Chesterfield Unit
Weekly Video Conference
Weekly Video Conference
Sheffield Gynaecology Oncology Centre
Weekly Video Conference
Weekly Video Conference
Doncaster & Worksop Unit
Rotherham Unit

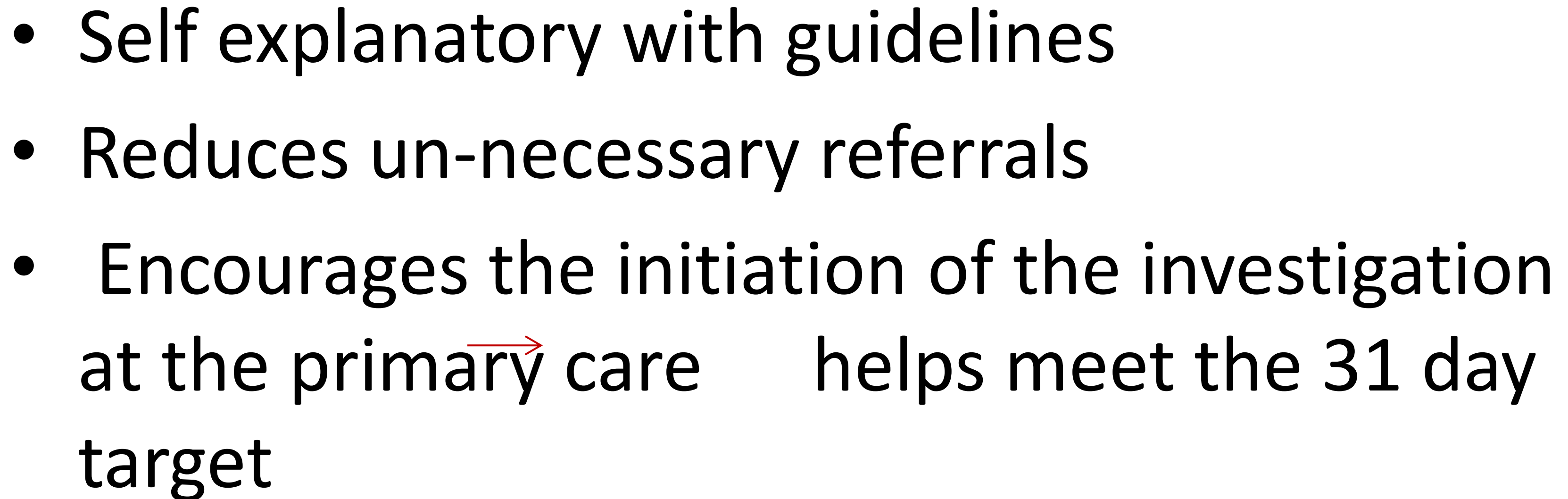
2ww Gynaecology service at Barnsley

- 2 Gynae. fast track clinics/ week.

  460 patients in 2005

  1000 patients in 2015
- One stop service for PMB (TVUS &Hysteroscopy)
- Weekly MDT
- Designated clinic for the follow-up

The New 2WW Referral form



- Self explanatory with guidelines
- Reduces un-necessary referrals
- Encourages the initiation of the investigation at the primary care → helps meet the 31 day target

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	

Ovarian Cancer

2WW referral if physical examination reveals:

- Ascites ☐
- Pelvic or abdominal mass ☐

Arrange urgent investigations CA125 and U/S scan (not necessarily within 2 weeks) [especially in women 50 or over] with any of the following on a persistent or frequent basis:

- Persistent abdominal distension/bloating
- Early satiety/or appetite loss
- Persistent pelvic or abdominal pain
- Increased urinary urgency and or frequency with negative MSU
- New onset symptoms suggestive of IBS
- Suspicious appearance on U/S scan and/or significantly elevated CA125

ALL referrals must be accompanied by up to date (strictly within last 28 days) U+E, FBC to allow timely onward investigation

Cervical/Vaginal Cancer

Refer 2WW:

Suspicious lesion on cervix or in vagina suggestive of cancer [do not delay a referral by performing a cervical smear] ☐

Vulval Cancer

Refer 2WW any suspicious vulval lump, ulcer or bleeding lesion. ☐

Endometrial Cancer

2WW referral is indicated for women 55 and over with post menopausal bleeding [Unexplained vaginal bleeding 12 months or more after menstruation has stopped due to the menopause]
If urgent trans-vaginal scan is available [within 2 weeks] consider this assessment prior to 2WW clinic referral to assess endometrium as high [4-5mm thickness or greater] or low risk [less than 4mm]

If no urgent scan available refer using 2WW form ☐
U/S scan suggests high risk, refer 2WW ☐
Consider direct ultra-sound referral for any woman 55 or over with unexplained vaginal discharge, thrombocytosis or haematuria. ☐

Reducing un-necessary Referrals

Conditions have been removed in the new form of referral:

- Persistent inter-menstrual bleeding with normal pelvic and speculum examination.
- Post-coital bleeding persistent for more than 4 weeks

Potential causes of Intermenstrual and Postcoital bleeding

- **Physiological:**

  Mid-cycle- 1-2% of normal cycles.

  Luteal phase defect

- **Trauma**

  Inadequate vaginal lubrication.

- **Contraception**

  Break-through bleeding is common with all preparations especially in the first few cycles. Usually self limiting.

  (Poor compliance , drug interactions or malabsorption)

Potential causes of Intermenstrual and Postcoital bleeding

- **Genital Tract Infection (Cervicitis/Endometritis)**

  Chlamydia → IMB or PCB (reported in 18%)

- **Cervix**

  Benign lesion (ectopy , polys, cervicitis)

  Dyskaryosis (17% of cases of PCB will have CIN)

  Cancer < than 1% of PCB cases with normal looking cervix and smear.

Potential causes of Intermenstrual and Postcoital bleeding

- **Endometrium**

  Benign lesions – polyps

  Hyperplasia and cancer generally present with menorrhagia or PMB

Potential causes of Intermenstrual and Postcoital bleeding

- **Initial Diagnostic work-up:**

Cervical smear (Repeat if clinically indicated)

Genital tract swabs including testing for chlamydia.

Contraception should be reviewed and change as appropriate

Potential causes of Intermenstrual and Postcoital bleeding

Key Points:

- **Most cases are benign and self –limiting**
- **Persistent IMB needs routine referral for hysteroscopy**
- **Cancer is <1% of cases presented with PCB with normal looking cervix and smear**

PMB

- **Trans-vaginal Ultrasound (TVUS)**

Strategies for the investigation and treatment of women presenting with PMB have evolved since the early 1990s with the advent of TVUS.

Because TVUS in PMB has an extremely high **NEGATIVE value** , it is reasonable to consider the first approach .

Looking for the ET

PMB

- **How thick is too thick?**

Reference	Endometrieal Thickness	No. of Women	No. of Cancer cases	Negative Predicted Value
Karlsson 1995	≤4mm	1.168	0	100%
Ferrazzi 1996	≤4mm ≤5mm	930	2	99.8%
Gull 2000	≤4mm	163	1	99.4%
Epstein 2001	≤5mm	97	0	100%
Gull 2003	≤4mm	394	0	100%

PMB

Causes of postmenopausal bleeding	
Endometrial/cervical polyps	2-12%
Endometrial hyperplasia	5-10%
Endometrial carcinoma	10%
Exogenus estrogens	15-25%
Arophic endometritis and vaginitis	60-80%

ET of Greater than 4 mm is not diagnostic of any pathology

PMB

- **2WW referral is indicated for women <u>55</u> and over ? (The new form)**
- The peak incidence for endometrial cancer is between 65 and 75 years of age, with average age at diagnosis is 61
- Mean age of Menopause is 51 years old.
- Because anovulatory cycles with episodes of multimonth amenorrhea are frequently precede menopause

PMB

- **However:**
- The age –specific incidence rate of endometrial cancer start to rise sharply around age 45
- Beware of High risk groups

  Obesity

  Diabetes mellitus

  Nulliparity

  Tamoxifen

  Menstrual factors (PCO)

The New form

- **We appreciate your help in completing the form**

- P S → help in the assessment and counselling
- Need hoisting → avoid delay in performing the tests.
- Relative will attend → avoid delay in the decision of investigation and treatment.

5.
2ww Urology
Cancer Referral

Mr. Colin Bunce

ConsultantUrologist

4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair	

ALL referrals must be accompanied by up to date (strictly within last 28 days) U+E, FBC to allow timely onward investigation

PROSTATE**

1.	Clinically malignant (Firm, hard or craggy) prostate on rectal examination (PSA to be checked but refer prior to result becoming available	☐
2.	- Raised Age adjusted PSA <50 >2.5; 50-59 >3.0; 60-69 >4.0; 70-79 >5.0; - Refer immediately if PSA >10ng/ml in patients <80 years of age.	☐
	- Refer patients over 80 years, if PSA >20 *In men with significant co-morbidities, performance status >3 or life expectancy <10 years, involve patient & family/carers and/or a specialist in discussion for the appropriateness of referral (patients best interest) ** (See guidelines)*	☐
3.	Clinical or Radiological suspicion of Bone Metastases	☐

KIDNEY & BLADDER ***

1.	➤ 45 yrs with unexplained visible haematuria without urinary tract infection.	☐
2.	➤ 45 yrs with unexplained visible haematuria that persists or recurs after UTI.	☐
3.	➤ 60 yrs with unexplained non-visible haematuria AND either dysuria or an elevated WBC on FBC.	☐
4.	➤ Clinical or radiological (US/CT scan) renal or bladder lesion suspicious of malignancy.	☐

Consider non-urgent referral for patients with non-visible haematuria > 60 yrs. old with recurrent or persistent UTI/Pyuria

TESTIS

1.	A solid mass within the body of the testis.	☐
2.	Non-painful enlargement or change in shape/texture of the testis.	☐

PENIS

1.	Penile mass or ulcerated lesion where a sexually transmitted infection has been excluded as a cause.	☐
2.	Persistent penile lesion after treatment for a sexually transmitted infection has been completed.	☐

Consider 2 week wait referral for penile cancer in men with unexplained or persistent symptoms affecting the foreskin or glans penis.

1.	Non-painful enlargement or change in shape/texture of the testis.	☐

PENIS

1.	Penile mass or ulcerated lesion where a sexually transmitted infection has been excluded as a cause.	☐
2.	Persistent penile lesion after treatment for a sexually transmitted infection has been completed.	☐

Consider 2 week wait referral for penile cancer in men with unexplained or persistent symptoms affecting the foreskin or glans penis.

CLINICAL GUIDANCE FOR URGENT UROLOGICAL CANCER REFERRALS

PATIENT MEDICAL HISTORY

Current medication:

Anticoagulants Y ☐ N ☐

Antiplatelets Y ☐ N ☐ **(excluding Aspirin)**

INVESTIGATIONS REQUIRED FOR REFERRAL

Suspected Prostate Cancer

PSA (Serial values if available)

	PSA ng/ml	Date
1.		/ /
2.		/ /
3.		/ /

Date:

MSU: ☐ **U+E:** ☐ **eGFR:** ☐ **FBC:** ☐

Symptoms, examination and any other information

DISCUSSIONS WITH PATIENT PRIOR TO REFERRAL

1. Has the patient been advised that this referral is to exclude a cancer diagnosis and has a 2WW patient referral leaflet been given? ☐
2. Has the patient been given information on their actual appointment, time and place? ☐
3. Is the patient available for their appointment in the next 2 weeks and do they understand how important it is to let the Practice and Hospital know ASAP if they cannot attend?

Paragraph Styles

GUIDANCE NOTES:

**PROSTATE

- At the discretion of the referrer, two PSA tests may be obtained 4-6 weeks apart (PSA elevated but <10ng/ml & Normal DRE) If PSA still >age adjusted value or increasing, refer immediately⌘
- If patient has a UTI & high PSA, repeat PSA 4-6 weeks after treating the patient. If PSA still above age specific limit, refer as 2WW suspected cancer.
- If initial PSA result is >10, and no UTI, an immediate urgent referral should be made in patients <80 years of age with good performance status.
- For raised or rising age-specific PSA in men with significant co-morbidities, performance status >3 or life expectancy <10 years, consider discussion with patient/family/carers and/or a specialist before urgent referral.
- Clinically malignant (Firm, hard, nodular or craggy) prostate on DRE - PSA should be measured but do not await result prior to referral.
- Patient with clinical or radiological suspicion of bony metastases of Prostatic cancer should be referred immediately as 2WW.

⌘Black men and those with a family history of prostate or breast cancer are at greater risk of developing prostate cancer.

For further information on prostate cancer, please consult the NICE guidelines and/or the Prostate Cancer Risk Management Programme. For CPD credits, consider the BMJ learning module on prostate cancer.

***KIDNEY & BLADDER

Initial investigations for a patient with s-NVH (symptomatic Non-Visible Haematuria) and persistent a-NVH (asymptomatic Non-Visible Haematuria)

- Exclude UTI and/or other transient cause.
- Check Serum Creatinine & eGFR.
- Check for proteinuria on a random sample. Send urine for protein:creatinine ratio (PCR) or albumin:creatinine ratio (ACR) on a random sample (according to local practice).
  N.B. 24 hour urine collections for protein are rarely required. An approximation to the 24 hour urine protein or albumin excretion (in mg) is obtained by multiplying the ratio (in mg/mmol) x10.
- Check Blood pressure
- In male or female patients with symptoms suggestive of a UTI and Visible Haematuria (VH), diagnose and treat the infection before considering referral. If infection is not confirmed, refer urgently.

For further information, please consult the Joint Consensus Statement on the Initial Assessment of Haematuria (Prepared on behalf of the Renal Association and British Association of Urological Surgeons. July 2008

TESTIS

- Swellings in the body of the testis- if unsure arrange an URGENT scrotal U/S and refer to 2WW clinic.

PENIS

- Symptoms or signs of penile cancer, including progressive ulceration or a mass in the glans or prepuce or involving the skin of the

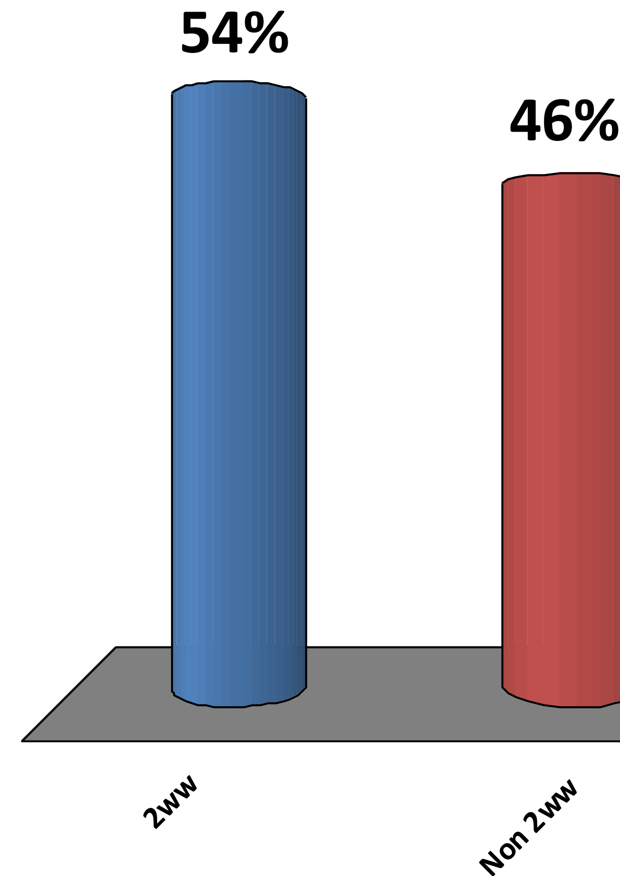
6. Two Week Wait Referrals to Dermatology

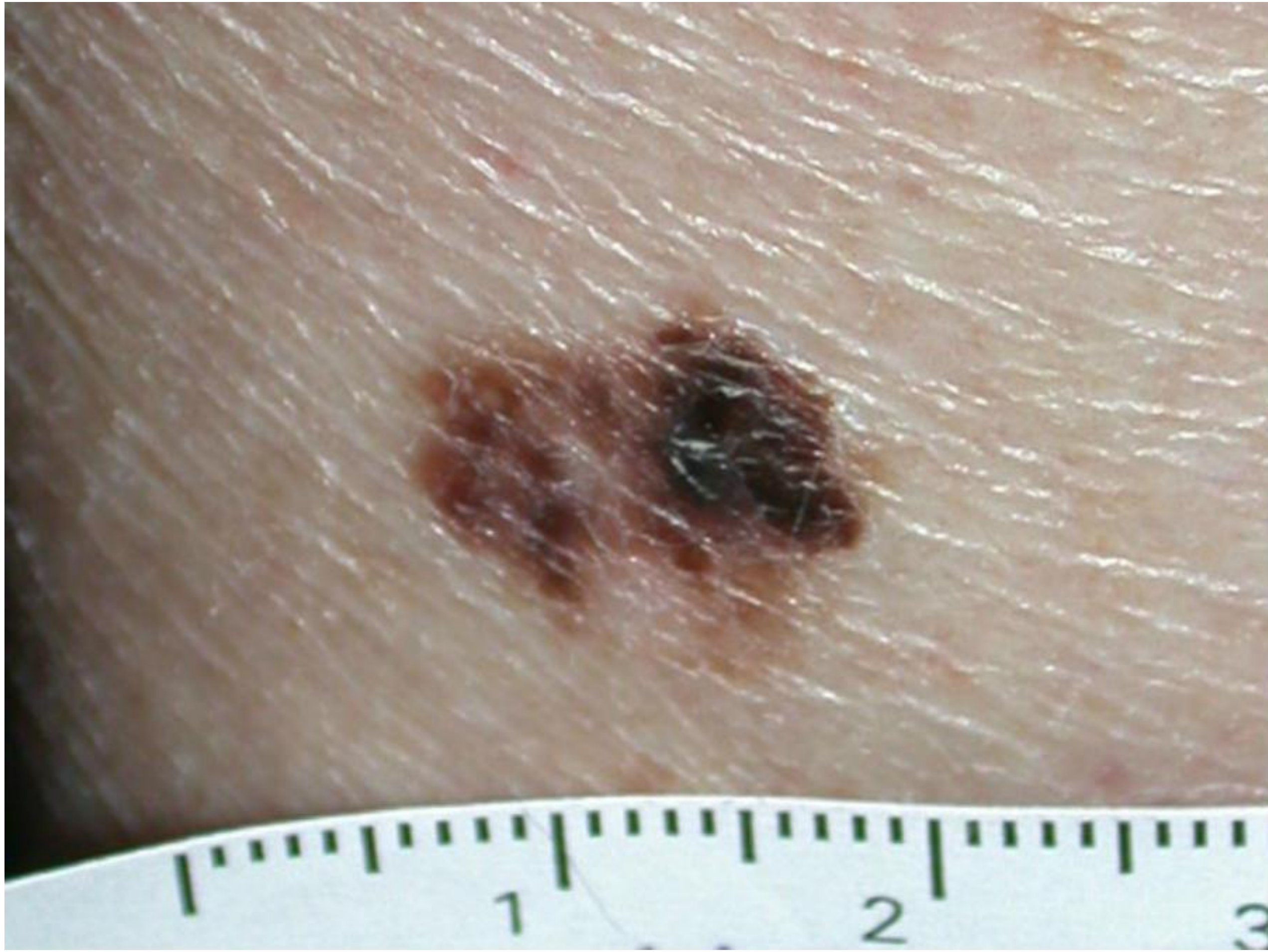
Nicola Hardcastle
Consultant Dermatologist
Barnsley Hospital NHS Foundation Trust

How would you refer this lesion ?

A. 2ww

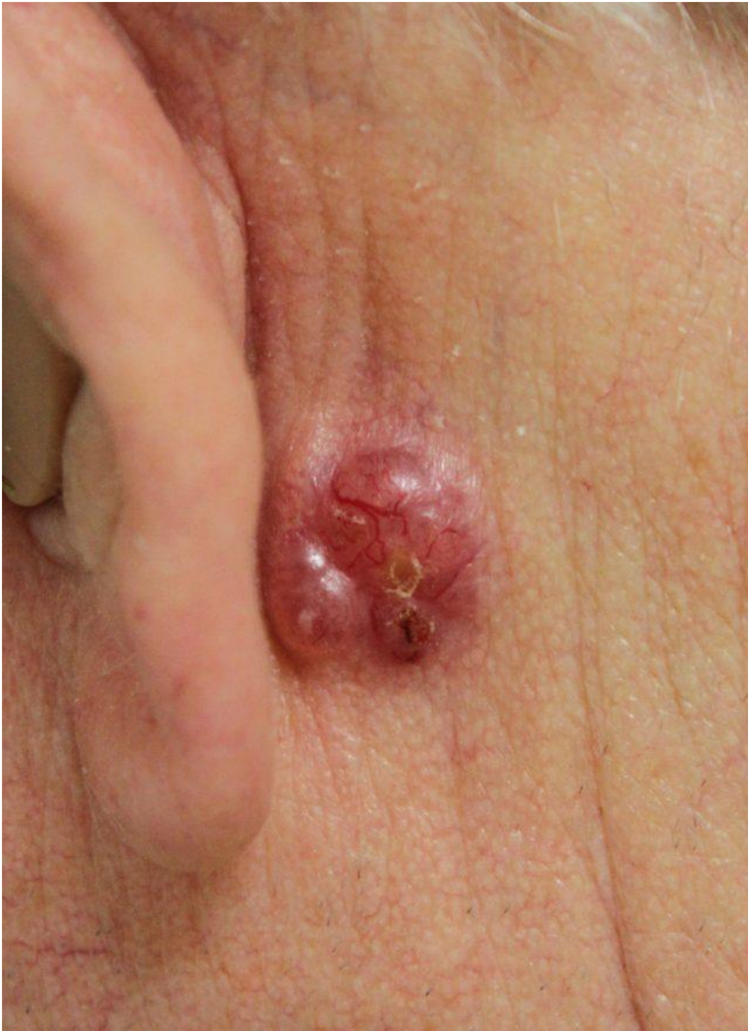
B. Non 2ww

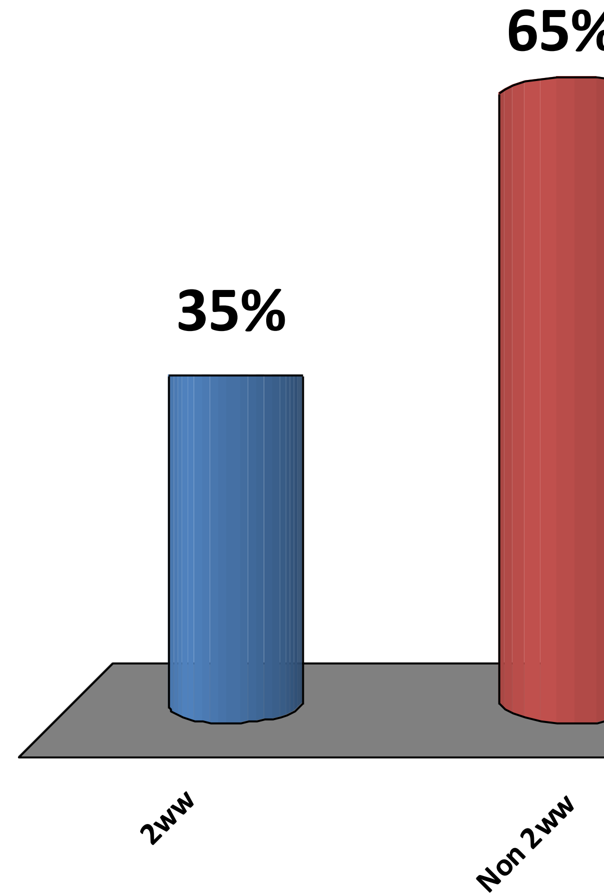



1
2
3

How would you refer this lesion ?

A. 2ww
B. Non 2ww

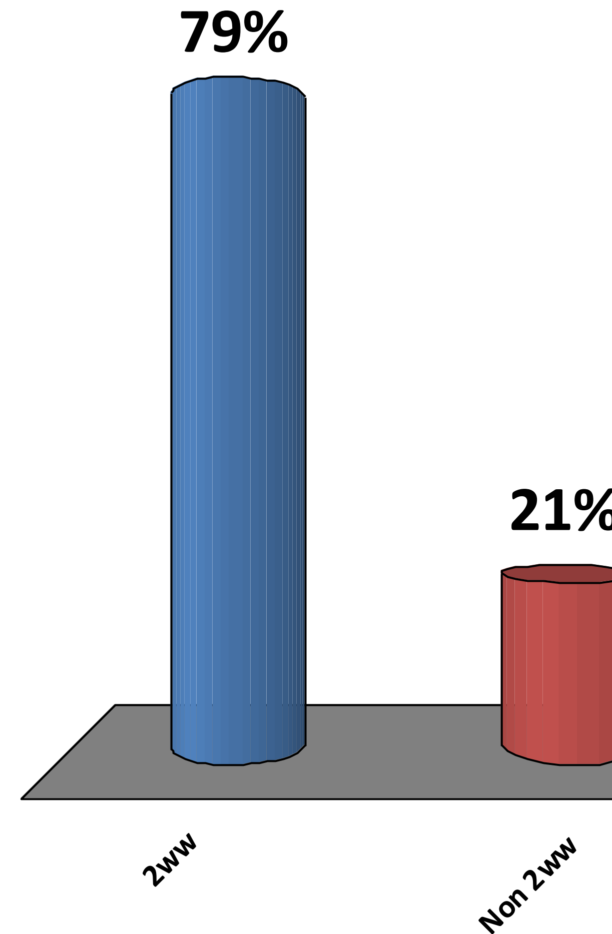




How would you refer this lesion ?

A. 2ww

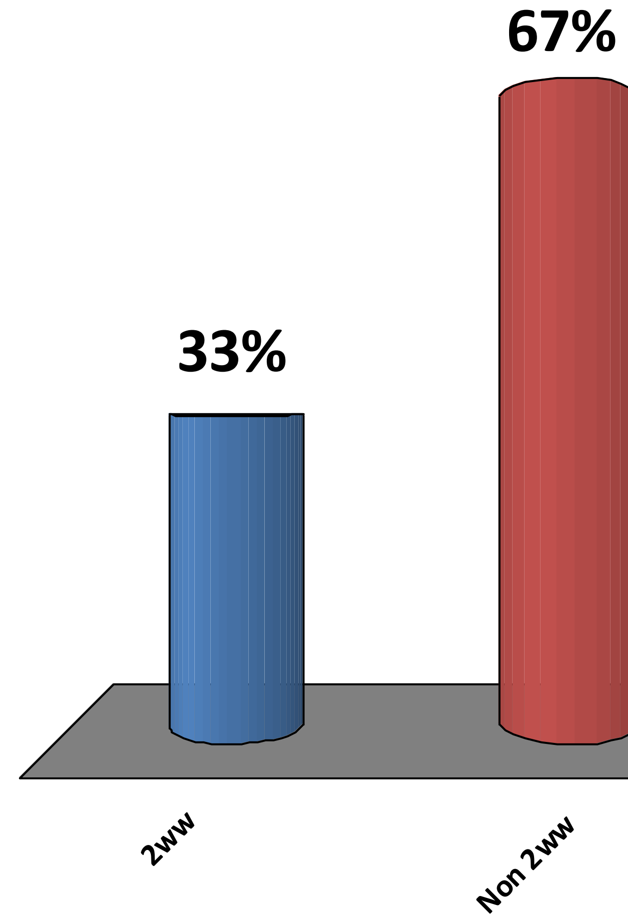
B. Non 2ww



How would you refer this lesion ?

A. 2ww

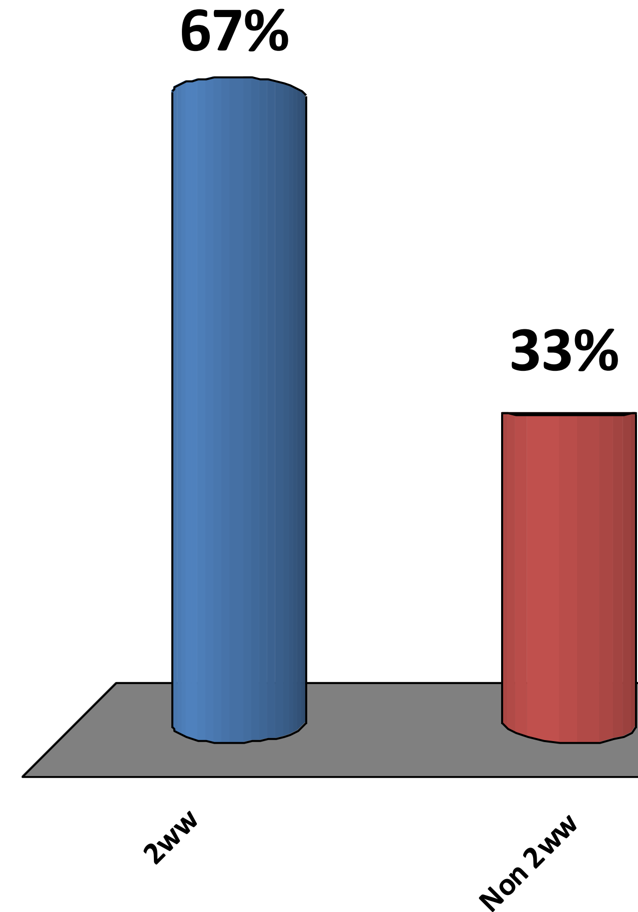
B. Non 2ww



How would you refer this lesion ?

A. 2ww

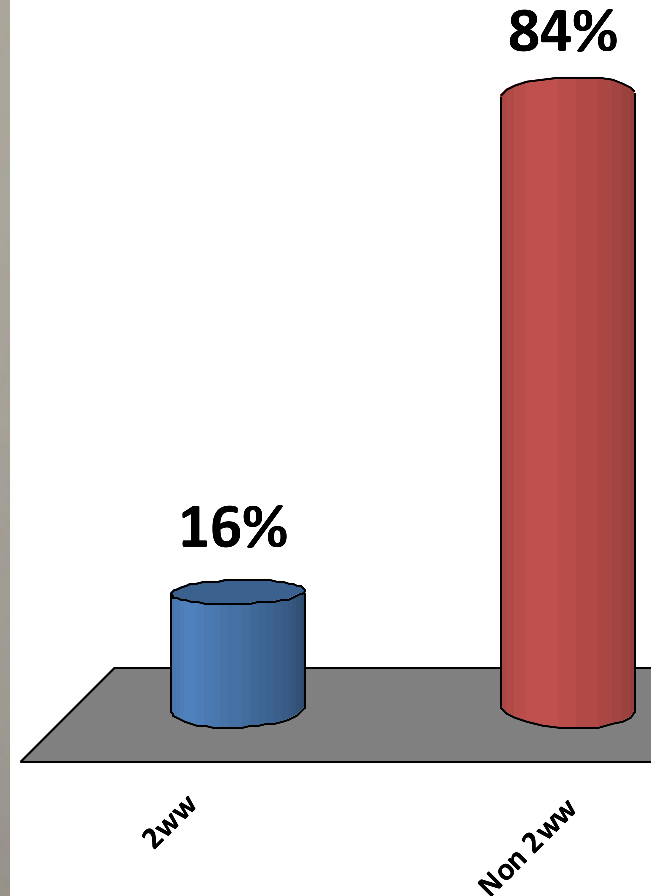
B. Non 2ww

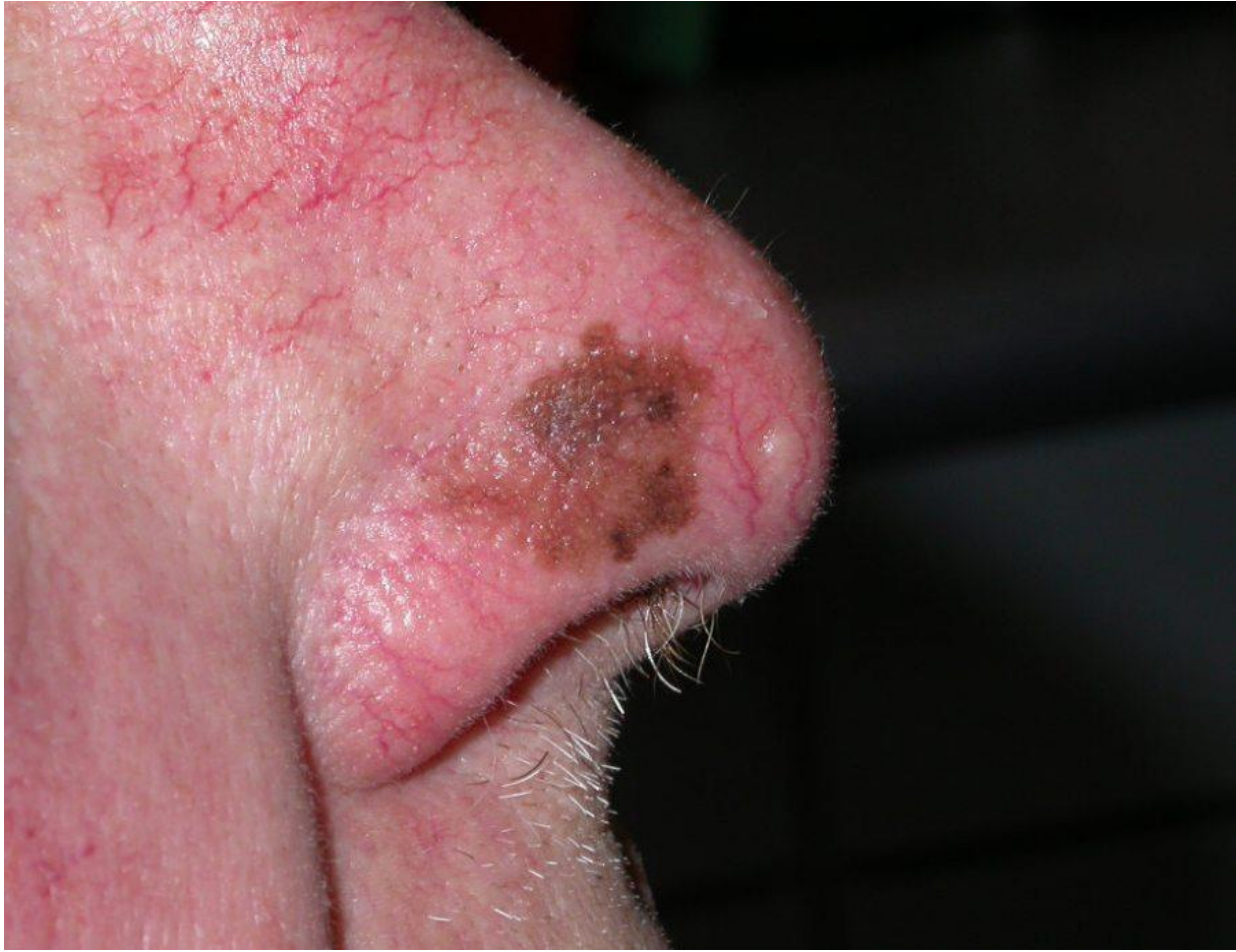


How would you refer this lesion ?

A. 2ww

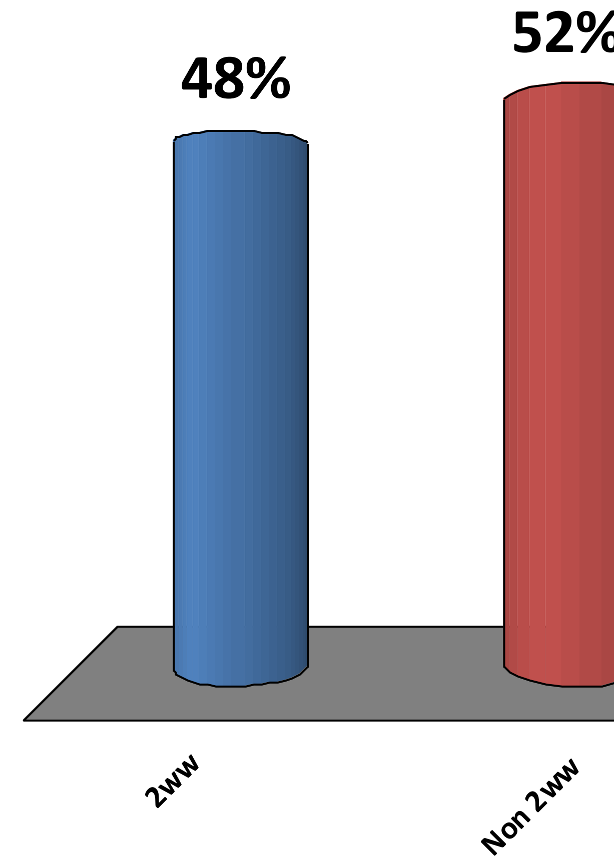
B. Non 2ww





How would you refer this lesion ?

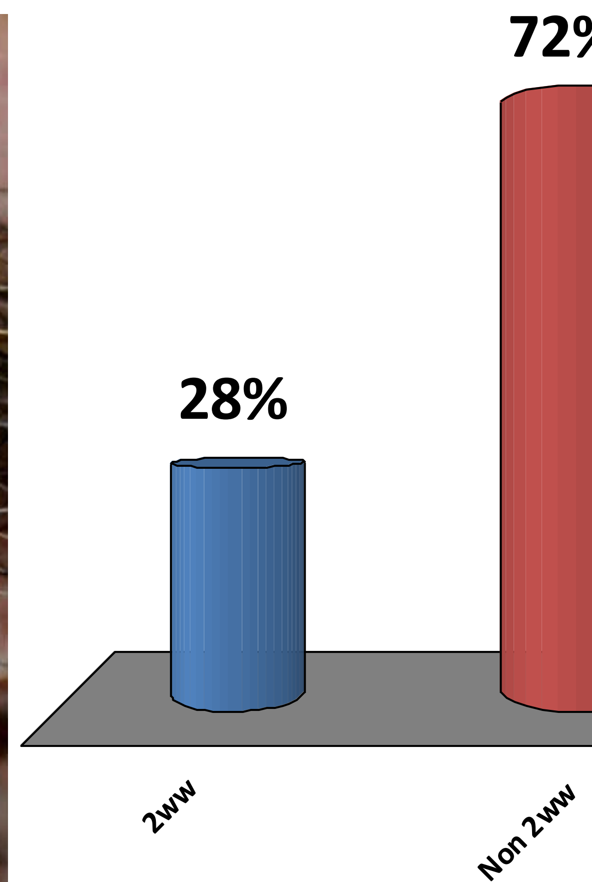
A. 2ww
B. Non 2ww

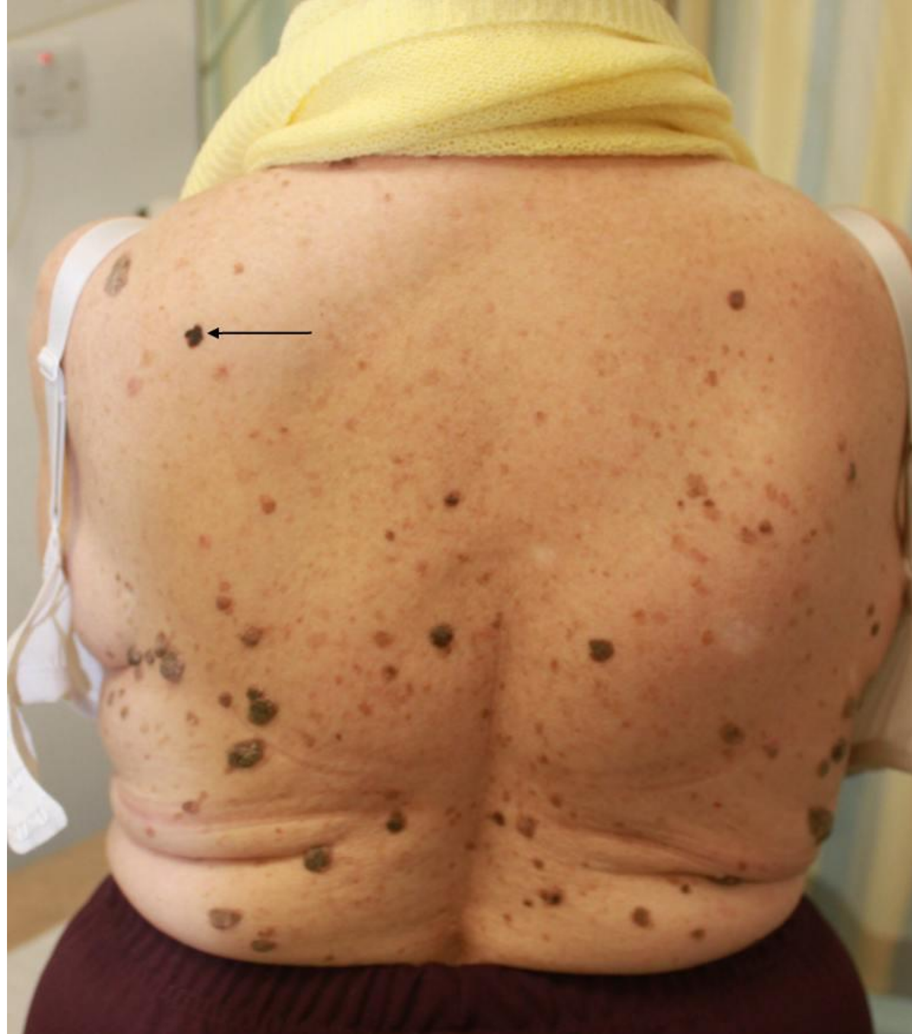


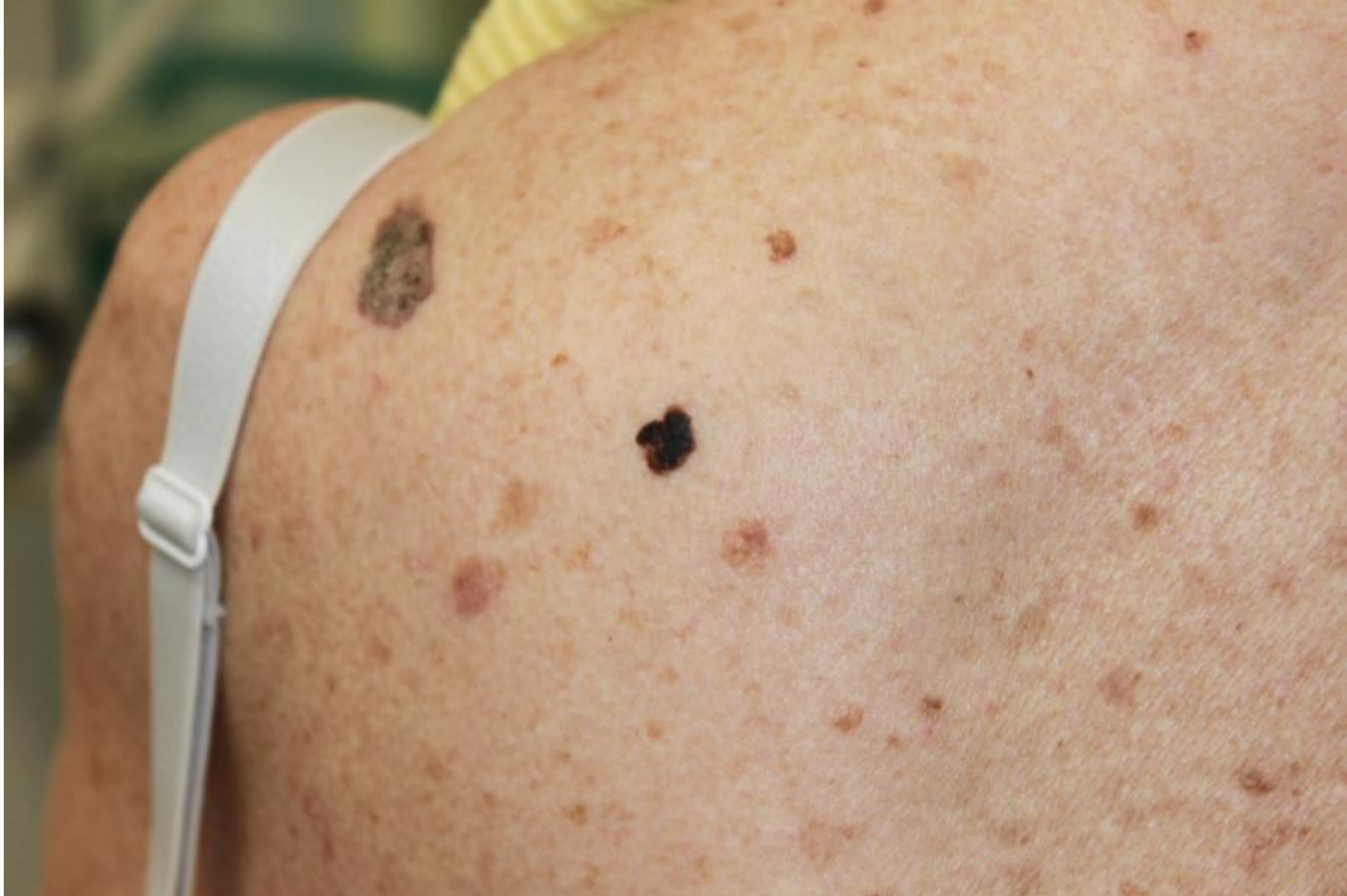
How would you refer this lesion ?

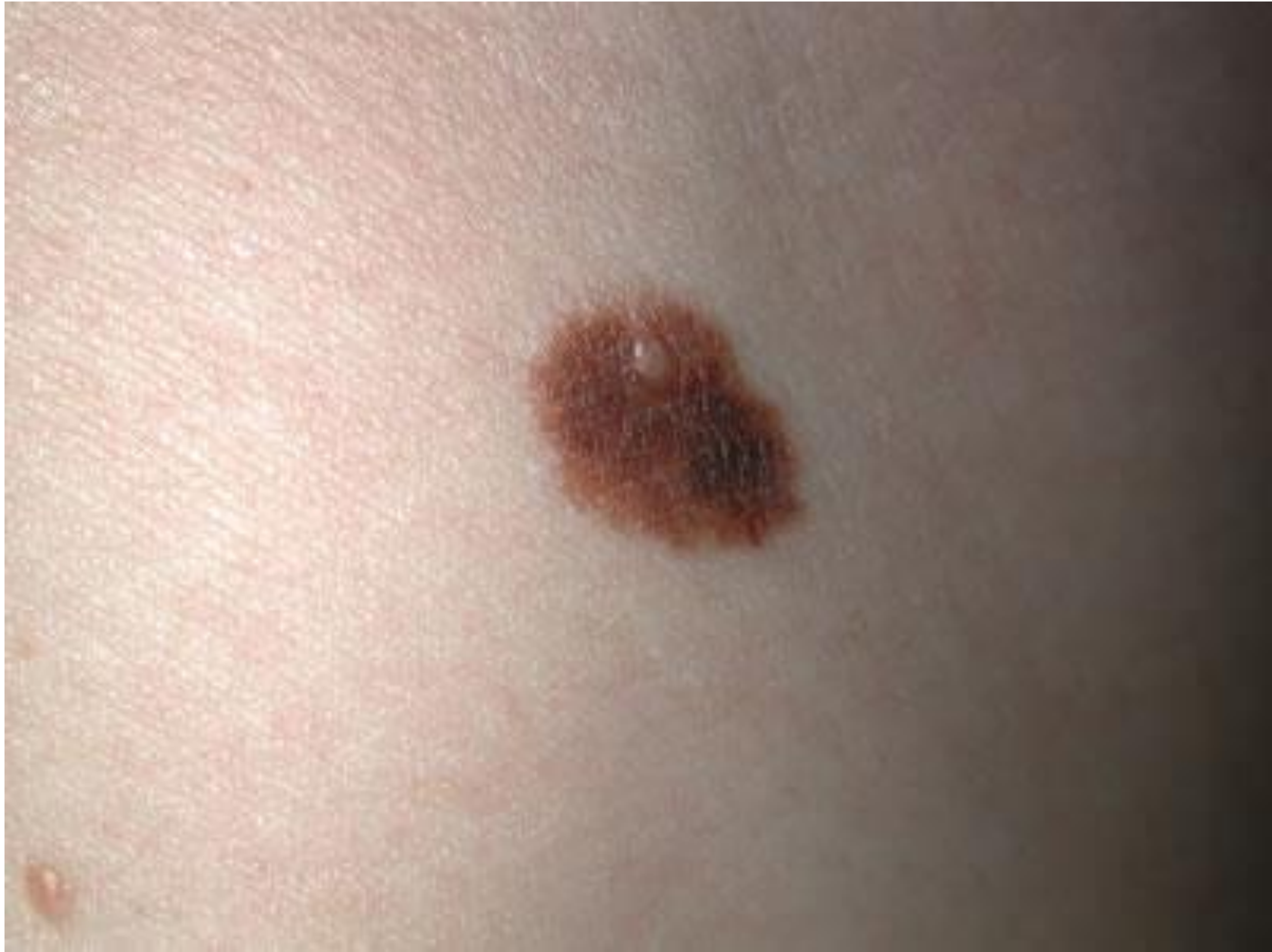
A. 2ww

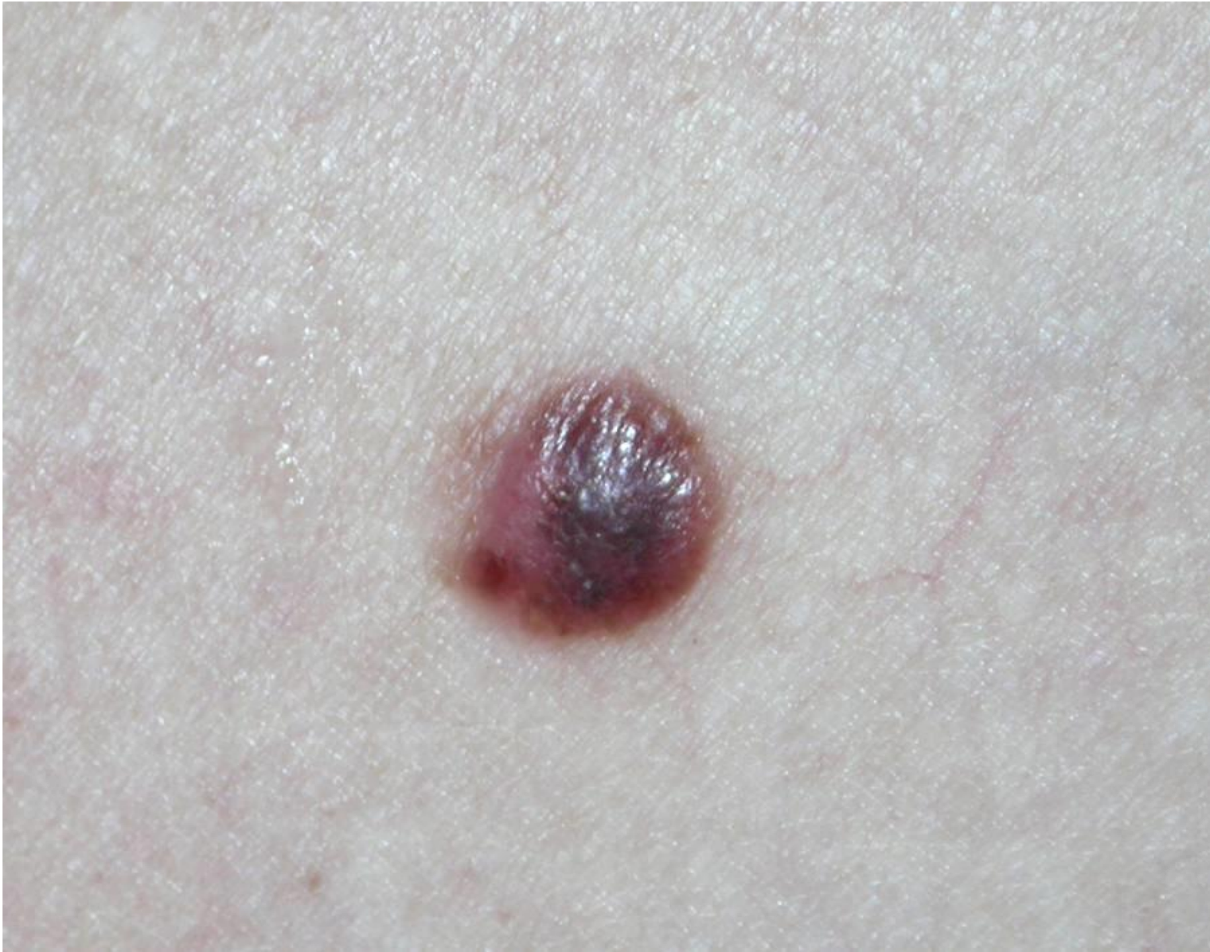
B. Non 2ww

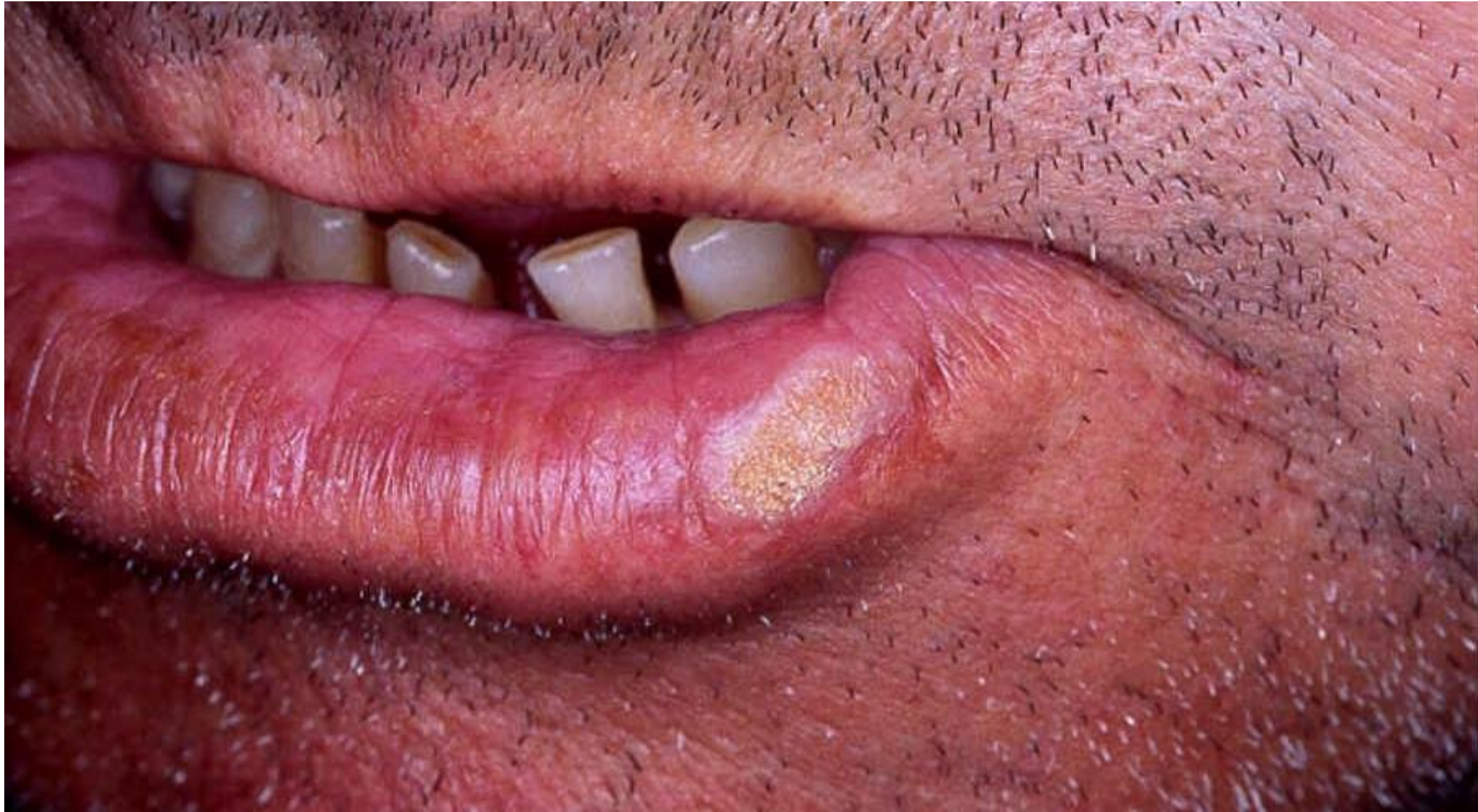


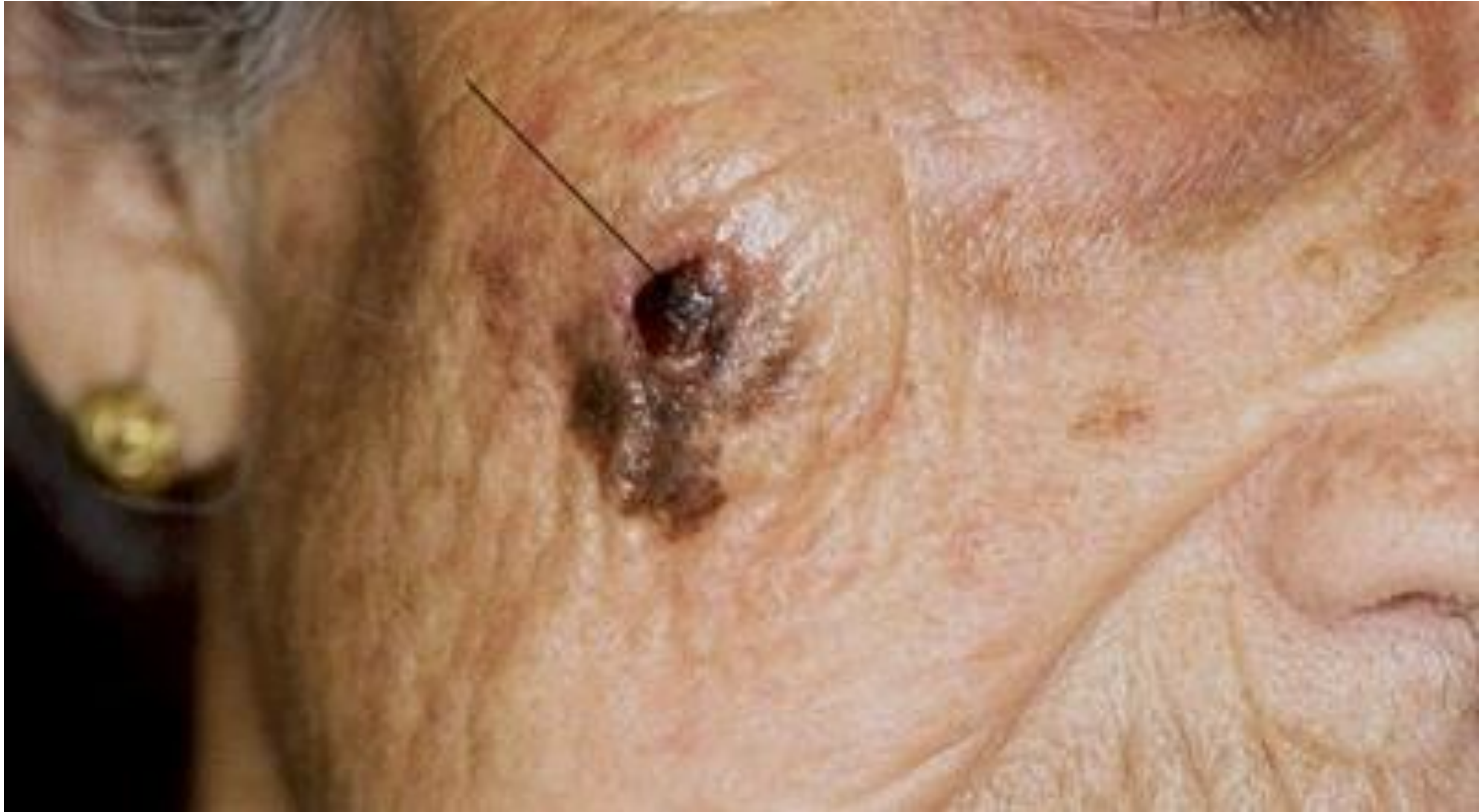


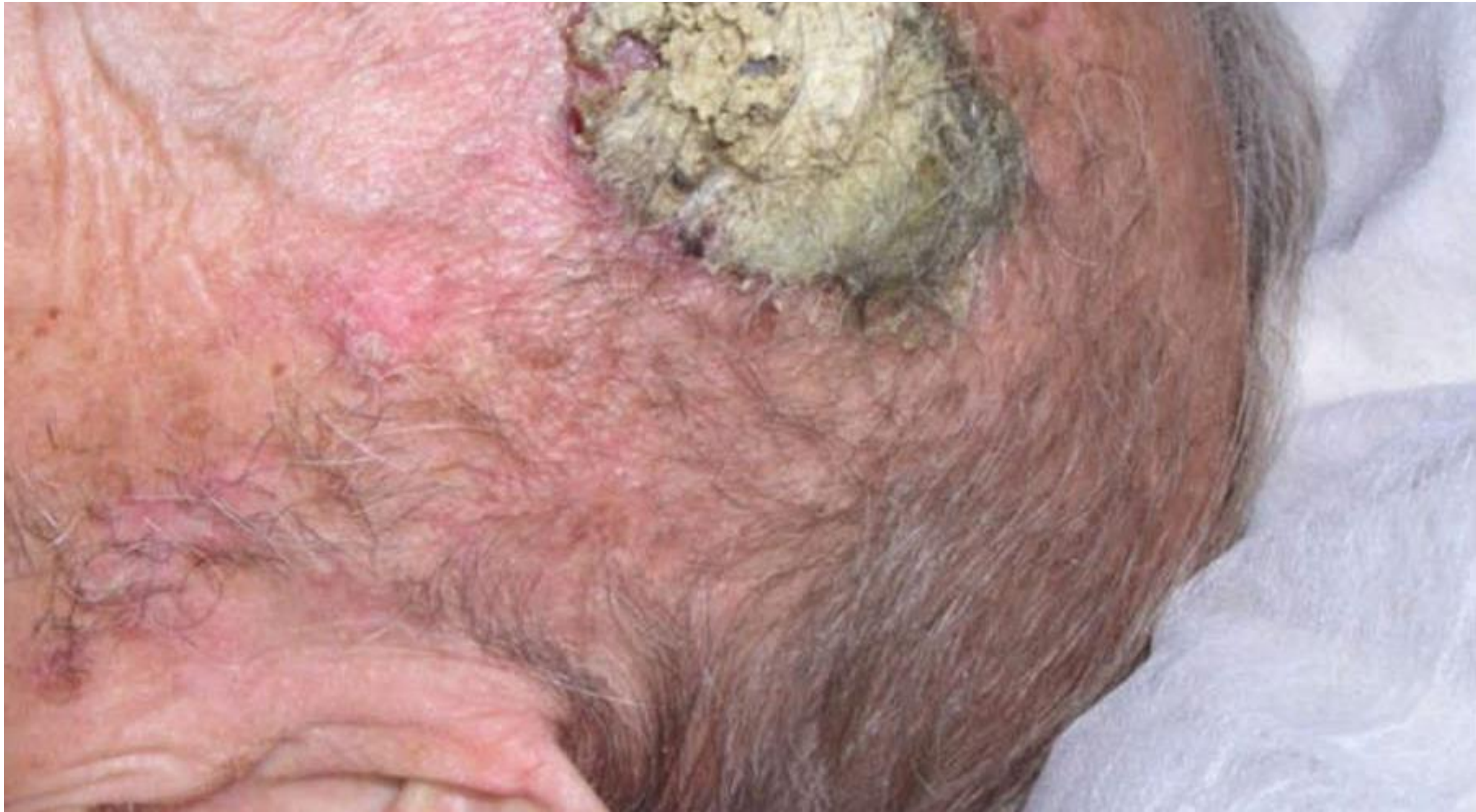


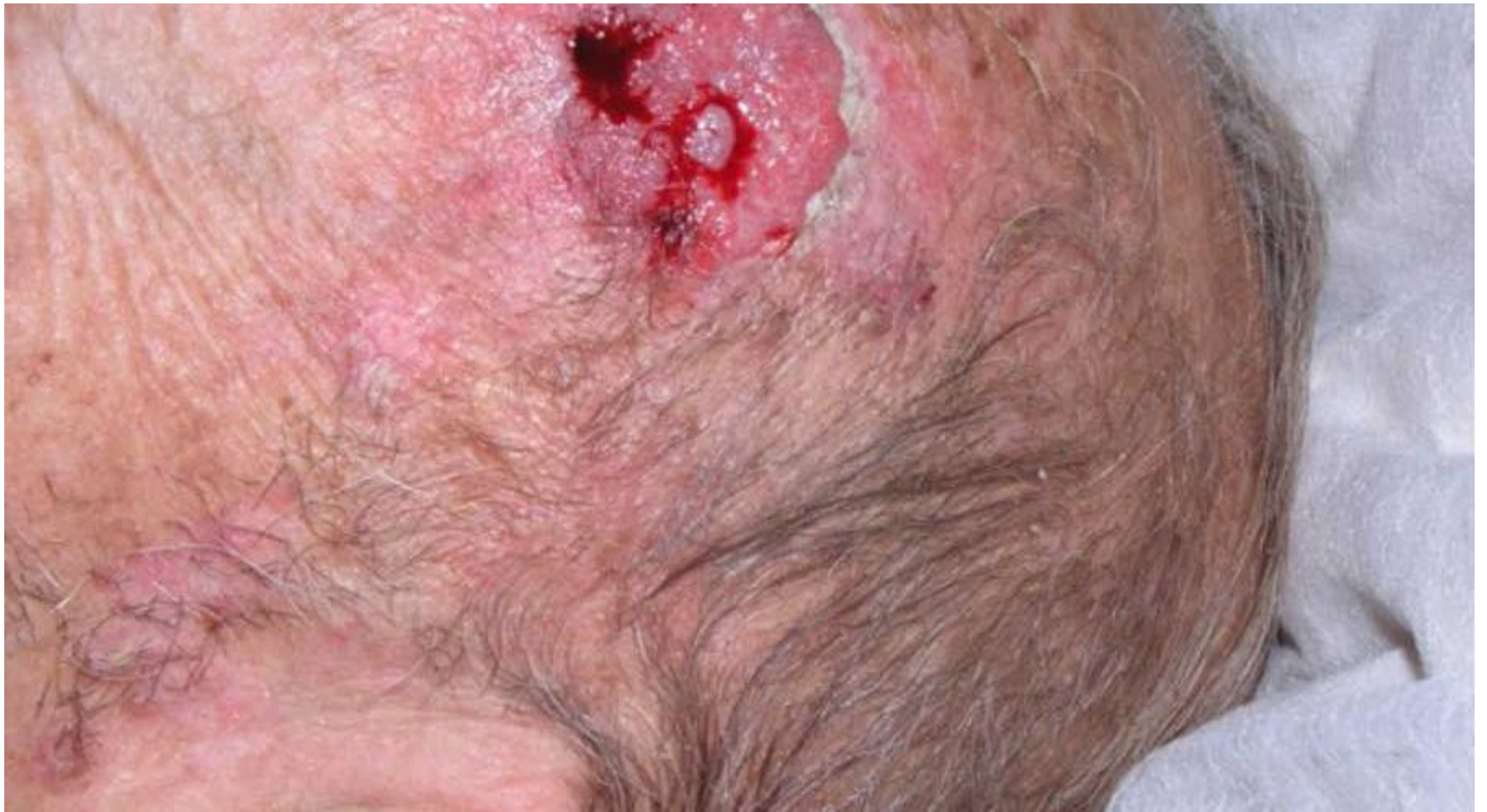












How would you refer this lesion ?

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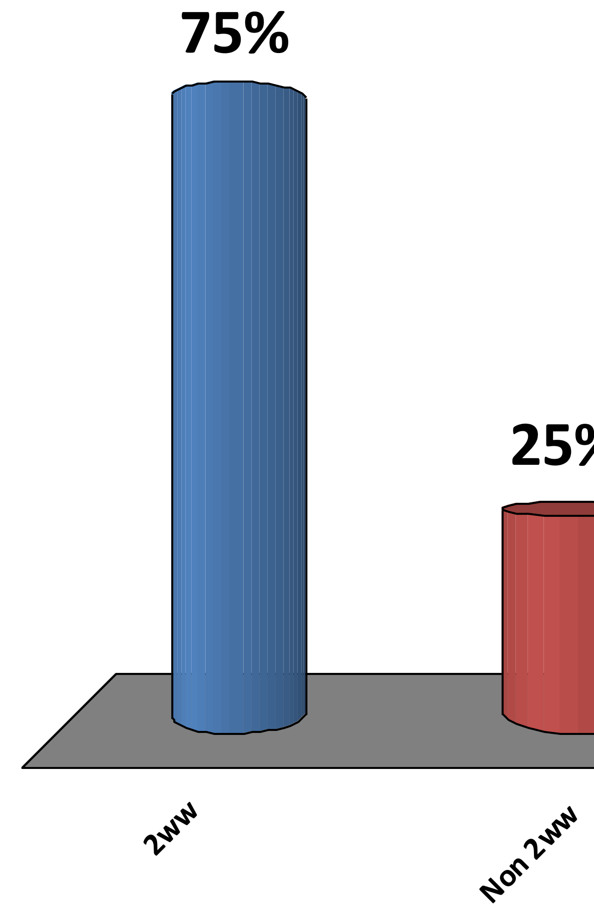
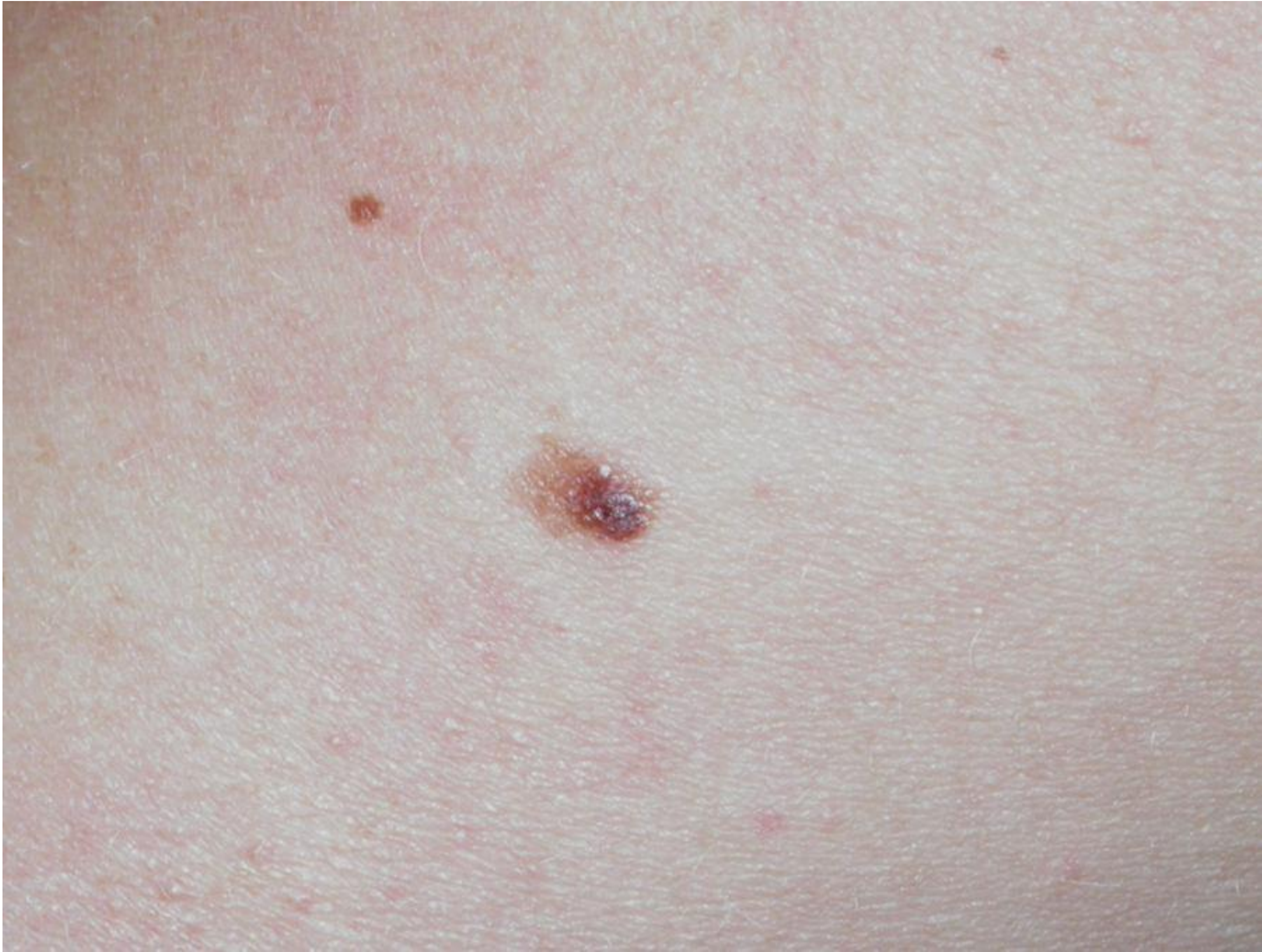
B. Non 2ww

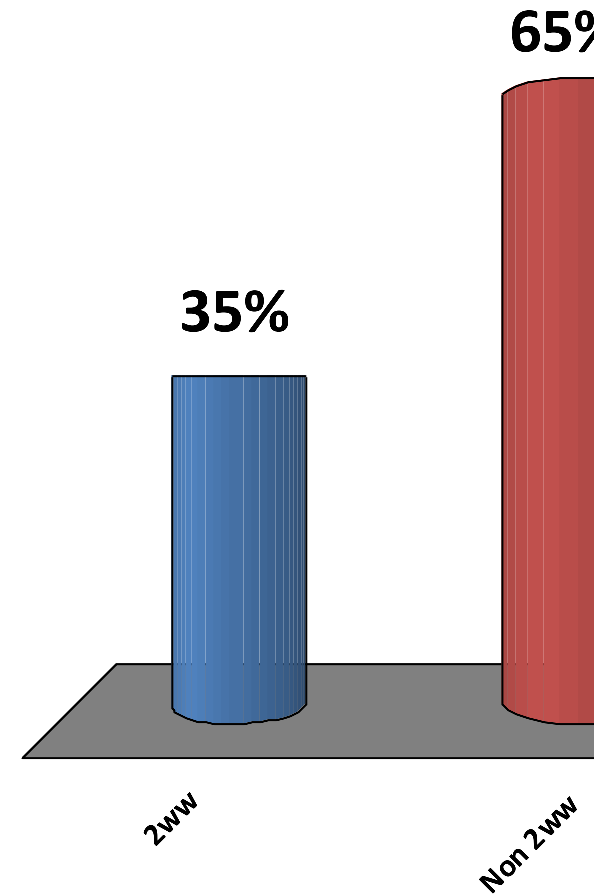


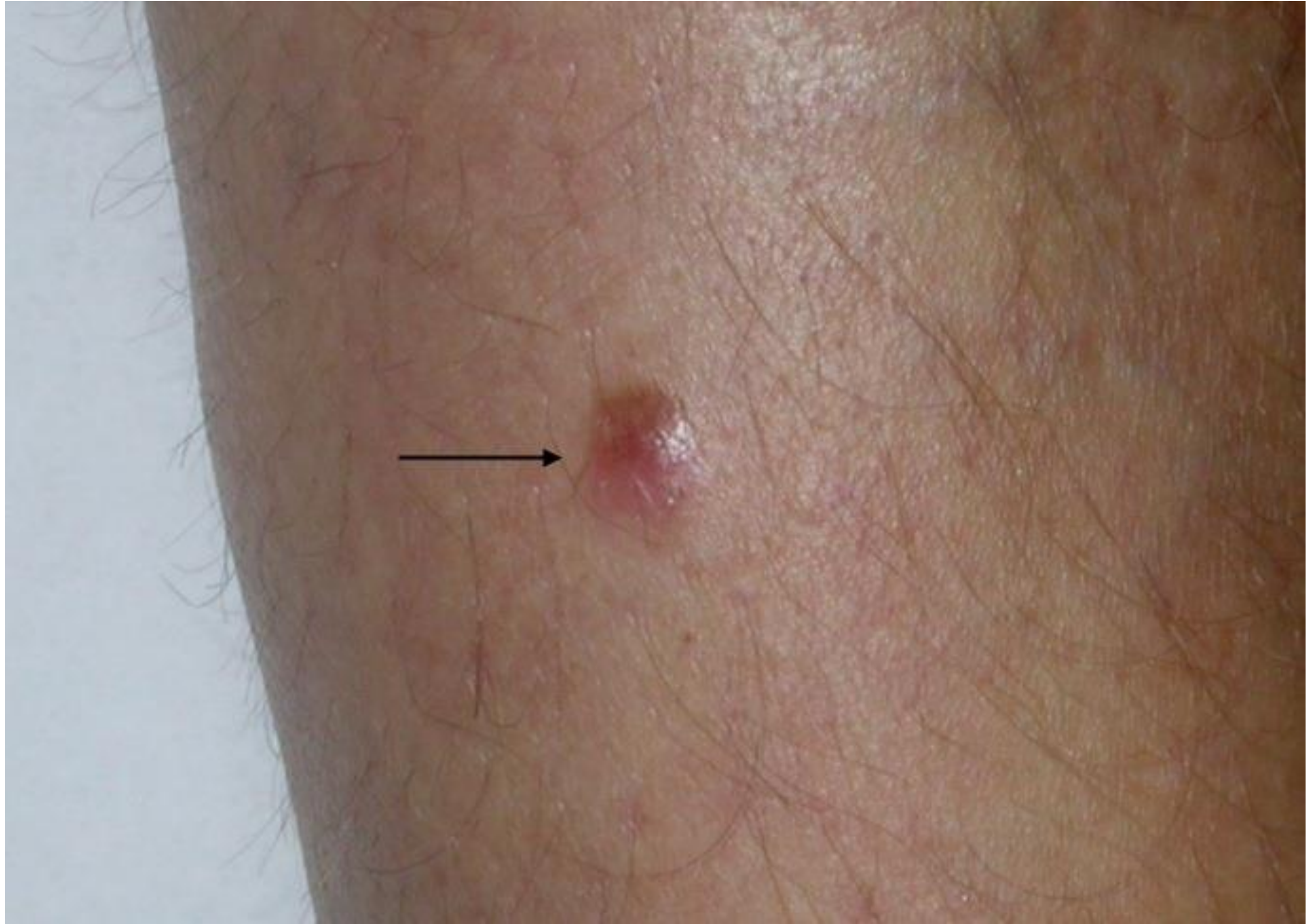


How would you refer this lesion ?

A. 2ww

B. Non 2ww





2WW SKIN URGENT SUSPECTED CANCER REFERRAL FORM (adult)

Date of GP decision to refer: __ /__ /

2WW skin referral form

This section must be completed. Thank you.

PATIENT DETAILS – *please provide multiple contact details*

Last name: First name:

Gender: M / F DOB: / / Ethnicity

NHS No:

Address:

Telephone No (Day):

Telephone No: (Evening)

Mobile No:

Patient agrees to telephone message being left: Y ☐ N ☐

Ambulance booking required: Y ☐ N ☐

Email:

Language: Interpreter: Y ☐ N ☐

GP/Clinician Details

GP/Clinician name and initials:

Practice code:

Address:

Telephone No:

Fax No:

Practice email address:

Referral Criteria

The criteria are compliant with 2015 NICE guidelines for referring those with suspected cancer and not a substitute for your own clinical judgement or taking specialist professional advice as appropriate.

This section must be completed. Thank you.

Performance Status (Adult) A WHO classification indicating a PERSON's status relating to activity/disability.

		Please Tick
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	

Urgent referrals criteria (tick category) – **ALL** referrals must be accompanied by up to date (strictly within last 3 months) U+E, FBC to allow timely onward investigation

Suspected Malignant Melanoma

Refer if suspicious pigmented skin lesions with a weighted 7-point checklist score of 3 or more:

- Major features of the lesion scoring 2 points each:
- Change in size
- Irregular shape
- Irregular colour

- Minor features of the lesion scoring 1 point each:
- Largest diameter 7mm or more
- Oozing/crusting
- Inflammatory response
- Change in sensation

Suspected Squamous Cell Carcinoma

Refer if rapidly growing non-healing lesion. Lesion may be tender, indurated, crusted, ulcerated, scaly or bleeding.

Suspected Basal Cell Carcinoma

Refer these lesions ***via non 2WW pathway*** unless concern about size and site having detrimental effect on outcome if not dealt with urgently. For practices piloting the teledermatology service please trial this route for a rapid response and possible direct booking to a minor surgery clinic.

Information to be included specific to this referral:

Location: Lower leg / back / face / scalp / back of hands / ears / other

Paragraph Styles

Referral Criteria

The criteria are compliant with 2015 NICE guidelines for referring those with suspected cancer and not a substitute for your own clinical judgement or taking specialist professional advice as appropriate.

This section must be completed. Thank you.

Performance Status (Adult) A WHO classification indicating a PERSON's status relating to activity/disability. **Please Tick**

		Please Tick
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	

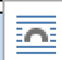
Urgent referrals criteria (tick category) – ALL referrals must be accompanied by up to date (strictly within last 28 days) U+E, FBC to allow timely onward investigation

Suspected Malignant Melanoma

Refer if suspicious pigmented skin lesions with a weighted 7-point checklist score of 3 or more:

- Major features of the lesion scoring 2 points each:
  - Change in size
  - Irregular shape
  - Irregular colour
- Minor features of the lesion scoring 1 point each:
  - Largest diameter 7mm or more
  - Oozing/crusting
  - Inflammatory response
  - Change in sensation

Refer for a pigmented or non-pigmented skin lesion that suggests nodular melanoma



Suspected Squamous Cell Carcinoma

Refer if rapidly growing non-healing lesion. Lesion may be tender, indurated, crusted, ulcerated, scaly or bleeding.

Suspected Basal Cell Carcinoma

Refer these lesions ***via non 2WW pathway*** unless concern about size and site having detrimental effect on outcome if not dealt with urgently. For practices piloting the teledermatology service please trial this route for a rapid response and possible direct booking to a minor surgery clinic.

Information to be included specific to this referral:

Location: Lower leg / back / face / scalp / back of hands / ears / other (Please specify) ___________________________

Duration of lesion and change

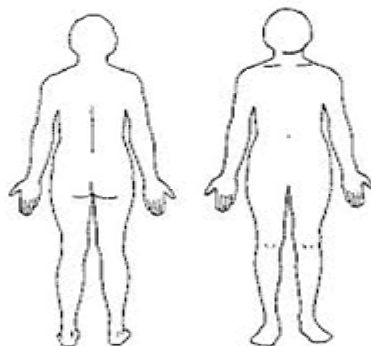
2WW SKIN URGENT SUSPECTED CANCER REFERRAL FORM (adult)

Date of GP decision to refer: __ /__ /

This section must be completed. Thank you.

History and Examination

For all lesions specify:



Please mark with X site/s of lesions

Site:

Size:

Nature of change:

Time period of change:

Description:

UV exposure:

Immune compromise risk:

Past Medical History

Current Medications

Allergies

This section must be completed. Thank you.

Discussions with patient prior to referral

1. Has the patient been advised that the referral is to exclude a cancer diagnosis and has a 2WW patient referral leaflet been given? ☐
2. Has the patient been given information on their actual appointment, time and place? ☐

Water – 5 minutes!!!

Louise Merriman
Jayne Sivakumar
Head and Neck…Mr. Nussbaumer
Breast…Miss Julia Dicks
Lung…Dr. Malik
Lower GI…Mr. Mehmood ?
Gynae…Mr. Khaled Farag
Urology…Mr. Colin Bunce
Dermatology…Dr.Nicola Hardcastle