# SUSPECTED HEAD & NECK CANCER REFERRAL FORM

Press the <Ctrl> key while you click here to VIEW REFERRAL GUIDELINES

**REFERRAL DATE:** ☐

**For Choose and Book referrals, attach this template to a referral in Choose and Book within 24 hours of creating the request - an appointment must be made for the patient before they leave the practice.**

Press the <Ctrl> key while you click here to VIEW LEAD CLINICIAN CONTACT INFORMATION

Please X the corresponding box for the hospital the referral is being made to and fax/send within 24 hours.

| Hospital | Phone | Fax | Email: select & copy OR <Ctrl>+click |
|---|---|---|---|
| ☐ Barnet | 0208 370 9079 | 020 8375 1977 | RF-tr.bcf2weekwaitreferrals@nhs.net |
| ☐ Chase Farm | 0208 370 9079 | 020 8375 1977 | RF-tr.bcf2weekwaitreferrals@nhs.net |
| ☐ BHRUT | 01708 435 065 | 01708 435 074/367 | |
| ☐ Barts & London | 020 7767 3333 | 020 3594 3278 | |
| ☐ Homerton | 020 8510 5099 | 020 8510 7832 | huh-tr.Cancerreferrals@nhs.net |
| ☐ Princess Alexandra | 01279 827 550 | 01279 827 171 | fasttrackreferrals@pah.nhs.uk |
| ☐ UCLH | 020 3447 9599 | 020 3447 9932 | uclh.2ww@nhs.net |
| ☐ Whipps Cross | 020 8535 6856 | 020 8928 8836 | |

☐ **Patient has previously visited selected hospital** **HOSPITAL No:** ☐

## PATIENT DETAILS

**SURNAME:** ☐ **FIRST NAME:** ☐ **TITLE:** ☐

**GENDER:** ☐ **DOB:** ☐ **NHS NO:** ☐

**ETHNICITY:** ☐ **LANGUAGE:** ☐

☐ **INTERPRETER REQUIRED** ☐ **TRANSPORT REQUIRED**

**PATIENT ADDRESS:** ☐ **POSTCODE:** ☐

**DAYTIME CONTACT☏:** ☐

**HOME☏:** ☐ **MOBILE☏:** ☐ **WORK☏:** ☐

**EMAIL:** ☐

## GP DETAILS (IF REFERRAL IS FROM DENTIST PLEASE ASK PATIENT FOR GP DETAILS)

**USUAL GP NAME:** ☐

**PRACTICE NAME:** ☐

**PRACTICE ADDRESS:** ☐

**BYPASS☏:** ☐

**MAIN☏:** ☐ **FAX:** ☐ **EMAIL:** ☐

## DENTIST DETAILS (ONLY COMPLETE THIS SECTION IF REFERRAL IS FROM DENTIST)

**DENTAL PRACTICE NAME:** ☐ **DENTAL PRACTICE ADDRESS:** ☐

**TEL NO:** ☐ **FAX NO:** ☐ **EMAIL:** ☐

**THIS REFERRAL IS FROM:** ☒ **GP** ☐ **Dentist**

**REFERRING CLINICIAN:** ☐

DOB: NHS no:

## CLINICAL DETAILS

**CANCER AREA SUSPECTED**

- ☐ Nose
- ☐ Sinus
- ☐ Pharynx
- ☐ Oral Cavity
- ☐ Salivary Gland
- ☐ Lip
- ☐ Larynx
- ☐ Thyroid
- ☐ Other (please specify):

**RISK FACTORS**

- ☐ Poor Diet
- ☐ Alcohol
- ☐ Smoker
- ☐ Occupation
- ☐ History of Head and Neck Irradiation

**SYMPTOMS/SIGNS**

**ENT**

- ☐ STRIDOR – Refer same day
- ☐ Hoarseness – For more than 4 weeks with normal CXR. Do CXR before referral.
- ☐ Sore throat – Persistent, no other cause
- ☐ Otalgia – Persistent, no other cause, unilateral

**NECK**

- ☐ Thyroid solitary nodule increasing in size
- ☐ Lump in neck – Unresolved neck masses for more than 3 weeks
- ☐ Parotid/Submandibular swelling – Unexplained, persistent

**MOUTH**

- ☐ Oral Swellings – For more than 3 weeks
- ☐ Ulceration of oral mucosa – For more than 3 weeks
- ☐ Red/White patches on oral mucosa if pain or sudden bleeding
- ☐ Tooth mobility – Unexplained, for more than 3 weeks

**Any other relevant symptoms not covered by the guidelines:**

**Duration of symptoms:**

**Family History of cancer including age at diagnosis:**

- ☐ I confirm that I have discussed the possibility with the patient that the diagnosis may be cancer
- ☐ I confirm that I have explained the two week wait appointment process to the patient

**Please hand the patient a copy of the URGENT REFERRALS PATIENT INFORMATION LEAFLET**

Press the <Ctrl> key while you click here to view the leaflet

**TFTs**

**FBC**

**ESR**

**CRP**

**LFTs**

**RELEVANT IMAGING STUDIES** **Please include date:** **and location:**

**PAST MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**