**Pan London Suspected Ocular Surface/Orbital/Intraocular Cancer & Retinoblastoma Referral Form**

**(For suspected EYELID CANCER please use the Pan London Suspected Skin Cancer Referral Form)**

[Press the <Ctrl> key while you click here to view the Pan London Suspected Cancer Referral Support Guide](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/guides/general)

**REFERRAL DATE**: 

**This form should be used to refer a patient to their hospital of choice via E-referral (e-RS).**

**ALL suspected cancer referrals MUST be sent via e-RS within 24 hours.**

[Press the <Ctrl> key while you click to view a list of London hospitals](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/web/ophthalmology)   
***Please check on e-RS if a hospital can accept the referral***

**PATIENT DETAILS**

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

**GENDER:**       **DOB:**       **AGE:****NHS NO:** 

**ETHNICITY:**        **LANGUAGE:** 

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

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

**DAYTIME CONTACT** **TEL:** 

**HOME TEL:**       **MOBILE TEL:**       **WORK TEL:** 

**EMAIL:** 

**CARER/KEY WORKER DETAILS**

**NAME:**       **CONTACT TEL:**       **RELATIONSHIP TO PATIENT:** 

**COGNITIVE, SENSORY OR MOBILITY IMPAIRMENT**

**COGNITIVE**   **SENSORY**  **MOBILITY**   **DISABLED ACCESS REQUIRED**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**SAFEGUARDING**

**SAFEGUARDING CONCERNS**

**PLEASE INCLUDE RELEVANT DETAILS:** 

**GP DETAILS**

**USUAL GP NAME:** 

**PRACTICE NAME:**       **PRACTICE CODE:**  

**PRACTICE ADDRESS:** 

**BYPASS TEL:** 

**MAIN TEL:**       **FAX:**       **EMAIL:** 

**REFERRING CLINICIAN:** 

**PLEASE DO NOT REFER THE FOLLOWING ON A SUSPECTED EYE CANCER REFERRAL PATHWAY**

* **Congenital hypertrophy of retinal pigment epithelium**
* **Simple naevi, if small and flat**
* **Simple naevi, if minimally raised with only drusen on the surface**

**FOR SUSPECTED EYELID CANCER PLEASE USE THE PAN LONDON SUSPECTED SKIN CANCER REFERRAL FORM.**

**REASON FOR SUSPECTED CANCER REFERRAL**

**This form has FIVE sections for specific tumours: intraocular tumour, retinoblastoma, conjunctival melanocytic tumour, melanocytic choroidal tumour, and iris nodule. These are followed by ONE general information section.**

**You will (usually) only need to complete one specific tumour section:**

**1. Please mark the diagram below to indicate the site of the suspected tumour.**

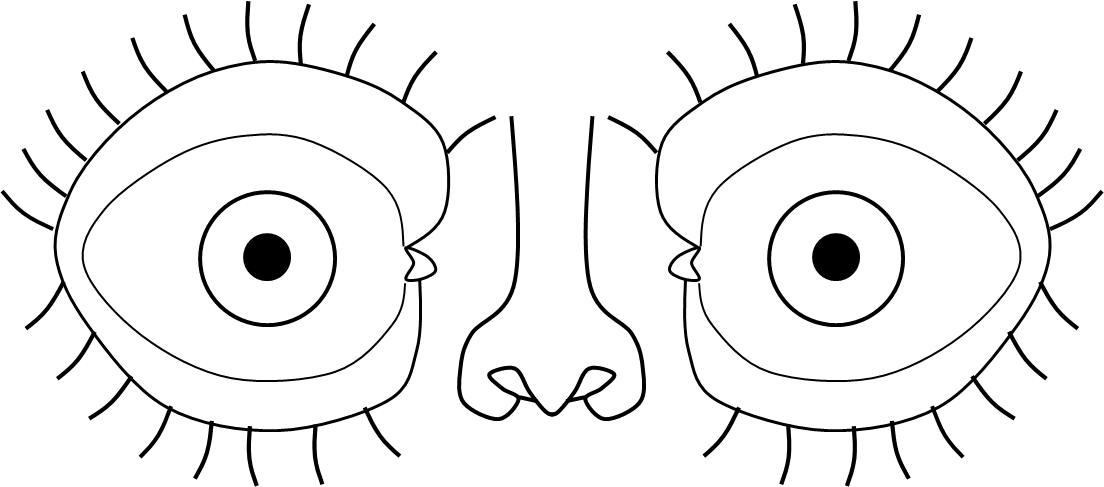
**2. With the patient’s consent, please also attach retinal or medical photograph to the referral form.**

**3. Check the box at the top left of the relevant specific tumour section and fill in the clinical details.**

**Scroll down to complete the GENERAL section. Please check the ROUTINE CLINICAL DATA inserted at the end of the form.**

[Press the <Ctrl> key while you click here to view Pan London Suspected Lid, Orbital, Retinoblastoma & Conjunctival Cancer Referral Guide](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/guides/ophthalmology)

**EYE TUMOUR DIAGRAM Describe here:**       **or mark diagram below.**

****

**Diagram shows everted eyelids revealing conjunctival sac**

**HOW TO MARK THE DIAGRAM ABOVE**

**Place the mouse cursor over the diagram at the position of the lesion. Click the left mouse button. Use the keyboard to mark the diagram (X marks the lesion). Use the mouse or arrow keys to move left or right or to adjacent lines. Please do not press the <ENTER> key as it may cause alignment problems with your markers.**

**WITH THE PATIENT’S CONSENT, PLEASE ALSO ATTACH RETINAL OR MEDICAL PHOTOGRAPH TO THE REFERRAL FORM IF AVAILABLE.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **INTRA-OCULAR TUMOUR** | | | | | |
|  | **Any primary intraocular tumour other than naevus** | | | | | |
|  | **Any intraocular metastatic tumour if specialist ocular oncology is required** | | | | | |
|  | **Suspected intraocular lymphoma** | | | | | |
|  | **Vision loss / change from the suspected tumour** | | | | | |
|  | **Proptosis / globe displacement** | | | | | |
|  | **CT / MRI showing an intraocular tumour** | | | | | |
| **Site:** | |  | **Left** |  | **Right** | **Duration:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **RETINOBLASTOMA**  **Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in INFANTS/CHILDREN with an absent red reflex.** | | | | | |
| **Site:** | |  | **Left** |  | **Right** | **Duration:** |

|  |  |
| --- | --- |
|  | **CONJUNCTIVAL MELANOCYTIC TUMOUR** |
|  | **Cornea, caruncle and/or palpebral conjunctiva is/are involved** |
|  | **Feeder vessels are present** |
|  | **Nodule is associated with diffuse pigmentation** |
|  | **Diameter exceeds 3 mm, especially in absence of clear cysts** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **MELANOCYTIC CHOROIDAL TUMOUR** | | | | | |
| **Any ONE of the following:** | | | | | | |
|  | **Thickness greater than 2.0 mm** | | | | | |
|  | **Collar-stud configuration** | | | | | |
|  | **Documented growth of a pigmented lesion at the choroid** | | | | | |
| **OR any TWO of the following:** | | | | | | |
|  | **Thickness > 1.5mm** | | | | | |
|  | **Orange pigment** | | | | | |
|  | **Serous retinal detachment** | | | | | |
|  | **Red eye and persistent conjunctivitis** | | | | | |
| **Site:** | |  | **Left** |  | **Right** | **Duration:** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **IRIS NODULE** | | | | | |
|  | **Tumour is more than 3.0 mm in diameter** | | | | | |
|  | **Tumour is markedly elevated** | | | | | |
|  | **Secondary glaucoma or cataract** | | | | | |
|  | **Tumour involves irido-corneal angle.** | | | | | |
| **Site:** | |  | **Left** |  | **Right** | **Duration:** |

**GENERAL INFORMATION ABOUT THIS REFERRAL**

**Referral is due to CLINICAL CONCERNS that do not meet NICE/pan-London referral criteria (the GP MUST give full clinical details in the ‘additional clinical information’ box at time of referral)**

**Additional clinical information:**

**Personal/relevant patient information:**

**Past history of cancer:**

**Relevant family history of cancer:**

|  |  |
| --- | --- |
|  | **I have discussed the possible diagnosis of cancer with the patient** |
|  | **The patient has been advised and confirmed they will be available for an appointment within the next two weeks** |
|  | **I have advised patient that they should prioritise this appointment. I have offered the pan London COVID -19 patient information leaflet. Offering written patient information increases patient experience and reduces non-attendance. These are available in 11 different languages.**  [Press the <Ctrl> key while you click here to view the leaflet](https://www.healthylondon.org/resource/covid-19-cancer-referral-resources/) |
|  | **This patient has been added to the practice suspected cancer safety-netting system**  [Press the <Ctrl> key while you click here to view information on Cancer Safety Netting Systems](https://www.healthylondon.org/wp-content/uploads/2020/04/Key-safety-netting-messages-during-Covid-19-pandemic-Final-version-9th-April-2020-003.pdf) |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **THIS SECTION IS FOR REFERRALS FROM SECONDARY CARE ONLY**  **If this is a confirmed cancer referral from secondary care, you MUST include the inter-provider transfer form.** | | | | | | | | |
| **If patient is on open cancer pathway, please tick one:** | | | | | | | | |
|  |  | **31 day** |  | **62 day** | | | | |
| **Diagnosis:** |  | **Orbital Tumour** |  | **Lid Tumour** |  | **Retinoblastoma** |  | **Conjunctival Tumour** |
| **Cancer is:** |  | **Probable** |  | **Possible** |  | **Definite** | | |

**INVESTIGATIONS**

**Please ensure this referral includes ALL the relevant investigations including blood tests and imaging. If there are any pending test results that you have organised at the time of this referral please provide information including TYPE OF INVESTIGATION requested (bloods, imaging) and TRUST performing the tests in the box below.**

**CLINICALLY-SPECIFIC AUTOMATIC TABULATED DATA**

**IMAGING STUDIES (in past 6 months) Please include date:       and location:**

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**

**OFFICE USE ONLY**