**Pan London Suspected Children's Cancer Referral Form**

**(patients aged under 16 yrs)**

[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:** 

**All referrals should be discussed with the local paediatrician on call within 24 hours and the patient should be referred to the paediatric department for an appointment within 48 hours.**

**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/childrens)   
***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:** 

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **The GP MUST ALWAYS discuss the patient with the local paediatrician on call and refer the patient to the paediatric department for an appointment within 48 hours** | | | | | | | | | | | | |
| **CANCER TYPE SUSPECTED** | | | | | | | | | | | | |
|  | **Leukaemia** | |  | | **Lymphoma** | |  | | | | **Brain Tumour** | |
|  | **Soft Tissue Sarcoma** | |  | | **Hepatoblastoma** | |  | | | | **Wilm’s Tumour** | |
|  | **Neuroblastoma** | |  | | **Unknown** | |  | | | |  | |
| **REASON FOR SUSPECTED CANCER REFERRAL**  **Children should be seen by a specialist WITHIN 48 HOURS.**  **Refer children and young people for IMMEDIATE SPECIALIST ASSESSMENT for leukaemia if they have unexplained petechiae or hepatosplenomegaly or if the results of a full blood count are suggestive of leukaemia.**  **Suspected Retinoblastoma - Use Pan London Suspected Ocular Surface/Orbital/Intraocular Cancer & Retinoblastoma Referral Form.**  **Suspected Skin Cancer - Use Pan London Suspected Skin Cancer Referral Form.**  **Suspected Bone Sarcoma - Use Pan London and South East Network Suspected Sarcoma Referral Form.**  [Press the <Ctrl> key while you click here to view Pan London Suspected Children’s Cancer Referral Guide](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/guides/childrens) | | | | | | | | | | | | |
| **Take into account the insight and knowledge of parents and carers when considering making a referral for a suspected cancer in a child or young person. Consider referral for child if their parent or carer has persistent concern or anxiety about the child’s symptoms, even if the symptoms are most likely to have a benign cause.** | | | | | | | | | | | | |
| **CLINICAL FEATURES** | | | | | | | | | | | | |
| **General** | | | | | | | | | | | | |
|  | **Weight loss** |  | | **Fatigue/malaise/lethargy** | | | | | | | | |
|  | **Appetite loss** |  | | **Nausea/vomiting** | | | | | | | | |
|  | **Unexplained fever** |  | | **Night sweats** | | | | | | | | |
|  | **Unexplained pruritus** |  | | **Unexplained persistent infection** | | | | | | | | |
|  | **Shortness of breath** |  | | **Pallor or other signs of anaemia** | | | | | | | | |
|  | **Unexplained persistent vague symptoms (3≥ consultations)** |  | |  | | | | | | | | |
| **Pain** | | | | | | | | | | | | |
|  | **Bone pain** |  | | **Abdominal pain** | | | | |  | | | **Unexplained headache** |
| **Urology** | | | | | | | | | | | | |
|  | **Unexplained visible haematuria** | | | | |  | | | |  | | |
| **Neurology** | | | | | | | | | | | | |
|  | **Fits** |  | | **Weakness** | | | |  | | | | **Dysphagia** |
|  | **Ataxia** |  | | **Torticollis** | | | |  | | | | **Facial nerve weakness** |
|  | **Behavioural change or deterioration in developmental milestones/school performance** | | | | | | | | | | | |
| **Soft tissue sarcoma** | | | | | | | | | | | | |
|  | **Unexplained soft tissue lump** | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| **EXAMINATION** | | | | | |
|  | **Skin lesions/oedema** |  | **Abdominal mass** |  | **Unexplained soft tissue lump** |
|  | **Chest signs** |  | **Splenomegaly** |  | **Hepatomegaly** |
|  | **Unexplained lymphadenopathy** |  | **Nerve palsy** |  | **Unexplained bruising** |
|  | **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)** | | | | |

**Summary of discussion with on-call paediatrician and 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/guardian** |
|  | **The patient/guardian has been advised and confirmed they will be available for an appointment within 48 hours** |
|  | **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 select 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) |

**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:**      

**RENAL FUNCTION (most recent recorded in past 6 months)**

**FBC (most recent recorded in past 6 months)**

**ESR (most recent recorded in past 6 months)**

**CRP (most recent recorded in past 6 months)**

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**

**OFFICE USE ONLY**