**Pan London & South East Sarcoma Network Referral Form**

**(FOR SUSPECTED SOFT TISSUE SARCOMA IN CHILDREN PLEASE USE THE PAN LONDON SUSPECTED CHILDRENS 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/sarcoma)   
***Please check on e-RS if a hospital can accept the referral***

**SOFT TISSUE Royal Marsden Hospital**

**(All tumour sites)** <http://www.lsesn.nhs.uk/files/contact-details.docx>

**SOFT TISSUE & BONE Royal National Orthopaedic Hospital**

**(Limb & trunk)** <http://www.lsesn.nhs.uk/files/contact-details.docx>

**SOFT TISSUE University College London Hospital**

**(Non-limb/trunk: e.g. head & neck, retroperitoneal, abdominal,urology,breast, skin etc.)**

<http://www.lsesn.nhs.uk/files/contact-details.docx>

**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:** 

|  |  |
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| **Please do not refer the following benign conditions using the Sarcoma 2WW form:** | |
| * **Subcutaneous lipomas** * **Sebaceous cysts/epidermoid cyst** * **Ganglions** * **Giant cell tumours of the tendon sheath** * **Pigmented villonodular synovitis (PVNS) of a joint** * **Post-traumatic or inflammatory phenomena such as fat necrosis, abscess** | * **Fibromas** * **Normal variant anatomy** * **Lymphangiomas/haemangiomas/all vascular malformations** * **chest wall/rib asymmetry** * **Tenosynovitis of the wrist (for wrist mass)** * **Sternoclavicular joint degeneration** |

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| **REASON FOR SUSPECTED CANCER REFERRAL**  [Press the <Ctrl> key while you click here to view Pan London Suspected Sarcoma Referral Guide](http://www.lsesn.nhs.uk/files/suspected-cancer-referral-guide.pdf)  **If you suspect sarcoma please complete ONE of the sections on this form.**  **1. SOFT TISSUE SARCOMA IN ADULTS: complete the section on this page (below)**  **2. PRIMARY BONE SARCOMA IN CHILDREN AND ADULTS: complete the section on the next page** |

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| **SUSPECTED SOFT TISSUE SARCOMA IN ADULTS**  **ALL SUSPECTED SOFT TISSUE SARCOMA IN CHILDREN SHOULD BE REFERRED TO THE LOCAL PAEDIATRIC SERVICE USING THE PAN LONDON SUSPECTED CHILDRENS CANCER 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) | |
| **Specific body site:** | |
|  | **Refer the patient with a soft tissue mass to a Sarcoma Diagnostic Service with an up-to-date Ultrasound or MRI which suggests soft tissue sarcoma** |
|  | **I do not have urgent direct access to ultrasound or MRI and there is a high clinical suspicion of cancer.** |
|  | **Recurrence following excision (please specify):** |
|  | **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 the time of referral and WE STRONGLY ADVISE YOU TO DISCUSS PATIENTS WHO HAVE NO PRIOR IMAGING WITH THE SARCOMA CENTRE BEFORE REFERRAL*.***  [Press the <Ctrl> key while you click here for contact details](http://www.lsesn.nhs.uk/files/contact-details.docx) |

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| **SUSPECTED PRIMARY BONE SARCOMA IN CHILDREN AND ADULTS** | | |
| **Specific body site:** | | |
|  | **Refer the patient to a Sarcoma Diagnostic Service with an x-ray that is suspicious and showing the following features:** | |
|  | **Spontaneous fracture** |
|  | **Bone destruction** |
|  | **New bone formation** |
|  | **Periosteal elevation** |
|  | **Normal or equivocal x-ray but high clinical suspicion of bone sarcoma** | |
|  | **Bone swelling or tenderness** | |
|  | **Bone pain (including night pain and pain not responding to simple analgesia)** | |
|  | **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.** | |

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| **IMAGING INVESTIGATIONS (please attach or send with form)** | | | |
| **Investigation** | | **Location of imaging department** | **Date of investigation** |
|  | **X-RAY** |  |  |
|  | **USS** |  |  |
|  | **CT** |  |  |
|  | **MRI** |  |  |

**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) |

**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**

**HISTOLOGY REPORTS Please include date:** **and location of laboratory:**

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

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

**ROUTINE AUTOMATIC TABULATED DATA**

**MEDICAL HISTORY**

**ALLERGIES**

**MEDICATION**

**OFFICE USE ONLY**