**Pan London Suspected CHILDREN’S Cancer Referral Form**

**All referrals should be sent via e-RS with this form attached within 24 hours**

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| Surname: «PATIENT\_Surname» | First name: «PATIENT\_Forename1» |
| Referral date: «SYSTEM\_Date» | NHS number: «PATIENT\_Current\_NHS\_Number» |
| Patient’s hospital of choice: [     ] [Click here to access the Hospitals Directory](https://www.transformationpartners.nhs.uk/programmes/cancer/early-diagnosis/two-week-wait-referral-repository/london-hospitals-taking-referrals-for-urgent-suspected-cancers/) | |

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| **THE GP MUST ALWAYS DISCUSS THESE PATIENTS WITH THE LOCAL PAEDIATRICIAN ON CALL** | | | | | | | | | | |
| ***The GP must discuss the patient with the local paediatrician on call and arrange appointment within 48 hours.***  ***Please do not use this form for suspected Skin Cancer, Bone Sarcoma, or Retinoblastoma - use the Pan London Skin Cancer, Sarcoma and Ophthalmology referral forms, respectively.*** | | | | | | | | | | |
| 1. **REASON FOR REFERRAL INCLUDING SUMMARY OF DISCUSSION WITH PAEDIATRIAN – ESSENTIAL**   *See* [Pan London Suspected Children’s Cancer Referral Guide](https://www.transformationpartners.nhs.uk/usc-childrens-cancer-clinical-guide/) | | | | | | | | | | |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:*** | | | | | | | | | | |
| **Cancer type suspected** | | | | | | | | | | |
| Leukaemia  Lymphoma  Brain Tumour  Hepatoblastoma  Wilm’s Tumour  Neuroblastoma  Soft Tissue Sarcoma  Unknown  ***If you suspect Skin Cancer, Bone Sarcoma, or Retinoblastoma use the appropriate Pan London referral form*** | | | | | | | | | | |
| **Clinical features** | | | | | | | | | | |
| **General:** | | | | | | | | | | |
|  | | Weight loss |  | Appetite loss | | | |  | Fatigue/malaise/lethargy | |
|  | | Nausea/vomiting |  | 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 | | | | | | | | | | |
| **Neurology:** | | | | | | | | | | |
|  | Fits | |  | Weakness | | | |  | Dysphagia | |
|  | Ataxia | |  | Torticollis | | | |  | Facial nerve weakness | |
|  | Behavioural change or deterioration in developmental milestones/school performance | | | | | | | | | |
| **Other:** | | | | | | | | | | |
|  | | Abdominal mass |  | | Splenomegaly |  | Hepatomegaly | | |
|  | | Unexplained soft tissue lump |  | | Chest signs |  | Skin lesions or changes including oedema | | |
|  | | Unexplained visible haematuria | | | | | | | |

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| 1. **ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL** | |
| **Confirm discussed case with on call Paediatrician**  Yes  No  ***Summary of discussion*** | |
| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL** | |
| **WHO Performance status** | |
| **0** Fully active  **1** Restricted physically but ambulatory and able to carry out light work  **2** Ambulatory more than 50% of waking hours; able to carry out self-care  **3** Limited self-care; confined to bed or chair more than 50% of waking hours  **4** Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair | |
| **Other access needs -** *please detail per the selected options in the field below* | |
| Interpreter required If Yes, Language:  Transport required  Wheelchair access required | Cognitive impairment including dementia  Learning disability ([see London LD contacts](https://www.england.nhs.uk/london/london-clinical-networks/our-networks/learning-disabilities/publications/))  Mental health issues that may impact on engagement  SMI |
| Details of learning disabilities, access needs and reasonable adjustments: | |

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| 1. **ADDITIONAL IMPORTANT CLINICAL INFORMATION** |
| Past history of cancer: |
| Relevant family history of cancer: |
| Safeguarding concerns: |
| Other relevant information about patient’s circumstances: |
| Patient referred/previously investigated for similar symptoms at other hospital/service?  No  Yes, please give details: |

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| I have discussed the **possible diagnosis of cancer** with the patient/ guardian [(Patient Information Resources)](https://www.transformationpartners.nhs.uk/programmes/cancer/early-diagnosis/two-week-wait-referral-repository/suspected-cancer-referrals/patient-information-leaflets/) |
| I have advised the patient to **prioritise this appointment and confirmed they’ll be available within the next 28 days.** |
| The patient/ guardian has been advised that the hospital care **may contact them by telephone** |
| Patient added to the practice **safety-netting system** and practice will review by DDMMYY *(manual entry)* |

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| 1. **REFERRER DETAILS** | |
| Usual GP name: «PATIENT\_Usual\_GP» | Referring clinician: «REFERRAL\_Clinician» |
| Practice code: | Practice address: «PRACTICE\_House» «PRACTICE\_Road», «PRACTICE\_Locality», «PRACTICE\_Town», «PRACTICE\_Postcode» |
| Practice name: «PRACTICE\_Name» | Email: |
| Main Tel: «PRACTICE\_Main\_Comm\_No» | Practice bypass numbers can be found using the [NHS Service Finder website](https://servicefinder.nhs.uk/) |

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| 1. **PATIENT DETAILS** | |
| Surname: «PATIENT\_Surname» | First name: «PATIENT\_Forename1» |
| NHS number: «PATIENT\_Current\_NHS\_Number» | Title: «PATIENT\_Title» |
| Gender on NHS record: «PATIENT\_Sex» | Gender Identity:       ***(manual entry)*** |
| Ethnicity: | |
| DOB: «PATIENT\_Date\_of\_Birth» | Age: «PATIENT\_Age» |
| Patient address: «PATIENT\_House» «PATIENT\_Road», «PATIENT\_Locality», «PATIENT\_Town», «PATIENT\_Postcode» | |
| Daytime contact Tel: **Work:** «PATIENT\_Main\_Comm\_No» **Home:** «PATIENT\_Alt\_Comm\_No» **Mobile**: «PATIENT\_Mobile\_No» | |
| Email: | |
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| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |
| 1. **CONSULATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS** | |
| ***Please note: You will need to add pending test results, requests and relevant excluded medical history (e.g. trans history, sexual health, private patients) manually in the text boxes below.*** | |
| Consultations:  «CURRENT\_CONSULTATION» | |
| Medical history:  «MEDICAL\_HISTORY» | |
| Medication:  «REPEATS» | |
| Allergies:  «DRUG\_ALLERGY» | |
| Imaging studies (in the past 6 months): Date:        Location: | |
| Test results pending (type of investigation) :       Trust / Organisation:       Date: | |
| All Values and Investigations (in the past 6 months): | |
| BMI (latest):  «PATIENT\_BMI» | |
| Weight (last three):  «PATIENT\_Weight» | |
| Blood Pressure (latest):  «PATIENT\_BP» | |
| Safeguarding history: | |
| Learning disability: | |
| Use of wheelchair: | |
| Accessible Information Needs (AIS): | |

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| *The content of these forms will be reviewed as part of regular cancer auditing.*  *Contact* [England.TCSTLondon@nhs.net](mailto:England.TCSTLondon@nhs.net) *to report any issues with this form.*  *DO NOT send referral forms with patient identifiable information to this email address.* |