**Pan London Suspected brain and cns Cancer Referral Form**

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

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| Surname: | First name: |
| Referral date: | NHS number: |
| Patient’s hospital of choice: [     ] [click here to access the hospitals directory](https://www.myhealth.london.nhs.uk/nhsrefer/formlinks/web/braincns) | |

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| 1. **REASON FOR REFERRAL – ESSENTIAL**   [*See* Pan London Suspected Brain & CNS Cancer Referral Guide](https://www.transformationpartnersinhealthandcare.nhs.uk/usc-brain-cancer-clinical-guide/) |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:*** |
| 1. **SPECIFIC CRITERIA FOR URGENT REFERRAL – ESSENTIAL** |
| Abnormal brain MRI/CT scan suggestive of cancer  Progressive, sub-acute loss of central neurological function  New onset seizures- focal or interictal focal deficit  Rapid personality change or behavioural disturbance/ slowness, witness confirmed with no reasonable explanation  Headache with sinister features suggestive of raised intracranial pressure  Isolated new onset daily headache duration of <12 weeks  Unexplained rapid cognitive changes  Cranial nerve palsy  Visual changes  History of malignancy with neurological symptoms  Referral is due to **clinical concerns that do not meet above criteria (full case description required in section 1)**  ***If no specific criteria are met, consider seeking Advice and Guidance from a specialist before referring*** |

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| 1. **INVESTIGATIONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL** |
| Direct access MRI  Brain CT  Direct access MRI or brain CT not available to GP |

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| 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 access needs: | |

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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 [(Patient Information Resources)](https://www.healthylondon.org/our-work/cancer/early-diagnosis/two-week-wait-referral-repository/suspected-cancer-referrals/patient-information-leaflets/) |
| I have advised the patient to **prioritise this appointment & confirmed they’ll be available within the next 14 days.** |
| The patient 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: | Referring clinician: |
| Practice code: | Practice address: |
| Practice name: | Email: |
| Main Tel: | Practice bypass number       ***(manual entry)*** |

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| 1. **PATIENT DETAILS** | |
| Surname: | First name: |
| NHS number: | Title |
| Gender on NHS record: | Gender Identity:       ***(manual entry)*** |
| Ethnicity: | |
| DOB: | Age: |
| Patient address: | |
| Daytime contact Tel:       **Home:**       **Mobile:** | |
| Email: | |
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| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |

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| 1. **CONSULTATIONS, 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: |
| Medical history: |
| Medication: |
| Allergies: |
| Imaging studies (in the past 12 months): Date:        Location: |
| Renal function (in the past 6 months): |
| Test results pending (type of investigation) :       Trust / Organisation:       Date: |
| All Values and Investigations (in the past 6 months): |
| BMI (latest): |
| Weight (latest): |
| Blood Pressure (latest): |
| Safeguarding history: |
| Learning disability: |
| Use of wheelchair: |
| Accessible Information Needs (AIS): |