**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: | 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/childrens) | |

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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.transformationpartnersinhealthandcare.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 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/ guardian [(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/guardian to **prioritise this appointment & confirmed available within the next 14 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: | 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\_Age» |
| Patient address: | |
| Daytime contact Tel:       **Home:**      **Mobile**: | |
| Email: | |
|  | |
| **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: | |
| Medical history: | |
| Medication: | |
| Allergies: | |
| Imaging studies (in the past 6 months): Date:        Location: | |
| Renal function (in the past 6 months): | |
| Full blood count (in the past 6 months): | |
| Erythrocyte Sedimentation Rate (ESR) (in the past 6 months): | |
| C-reactive protein test (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): | |