**Pan London Suspected head and neck Cancer Referral Form – Dental team**

**All referrals should be sent via secure email\* with this form attached within 24 hours**

For referrals **to GSTT** please close this form and go to: <https://www.smartsurvey.co.uk/s/SELdentalreferrals/>

For all other referrals look up your local hospital head and neck team contact: [Hospital Directory for Head & Neck](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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| Referral date: [ ] |

\*[Email must meet DCB1596 to be GDPR compliant](https://digital.nhs.uk/services/nhsmail/the-secure-email-standard)

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

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| 1. **REASON FOR REFERRAL– ESSENTIAL**   [*See* Pan London Suspected Head and Neck Cancer Referral Guide](https://www.transformationpartners.nhs.uk/usc-head-and-neck-cancer-clinical-guide/) |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:***  [ ] |

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| 1. **SPECIFIC CRITERIA FOR URGENT REFERRAL – ESSENTIAL** |
| **Criteria for urgent referral ORAL/LIP CANCER:** |
| ≥ 3 weeks of unexplained ulceration in the oral cavity  Suspicious lump/mass on the lip or in the oral cavity  Red/ Red& white patch in the oral cavity suggestive of leukoplakia or erythroleukoplakia  Tooth mobility not associated with periodontal disease  Poor healing ≥ 3 weeks post tooth extraction |
| **Criteria for urgent referral SALIVARY CANCER:** |
| Parotid **OR** submandibular swelling  Firm sub-mucosal swelling in the oral cavity |
| Referral is due to **clinical concerns that do not meet above criteria (full case description required in section 2)** |
| **Clinical risk factors**  Alcohol history  HPV  HIV  Previous irradiation to head and neck  Family history of thyroid cancer  Ex-smoker  Oral tobacco use  Current smoker [ [ ] packs per day [ ] years smoked] |

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| 1. **REFERRER DETAILS – ESSENTIAL** | |
| Referring clinician: [ ] | Referring clinician contact number: [ ] |
| Dental practice: [ ] | Referring clinician email: [ ] |
| General Practice name: [ ] ***It is important to include GP details, especially where NHS number is not known***  If general practice not known please tick box | |

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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 (Complete as much as possible)-** *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 (Complete as much as possible)** |
| Past history of cancer: [ ] |
| Relevant family history of cancer: [ ] |
| Safeguarding concerns: [ ] |
| Other relevant information about patient’s circumstances: [ ] |

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| I have discussed the **possible diagnosis of cancer** with the patient [(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 & confirmed they’ll be available within the next 28 days** |
| The patient has been advised that the hospital care **may contact them by telephone** |
| I have informed the patient’s GP of referral or **discussed this referral with the GP** so they can be safety-netted |

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| 1. **CONSULTATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS (Complete as much as possible)** | |
| ***Provide as much information as possible including pending test results, requests and relevant excluded medical history (e.g. trans history, sexual health, private patients) in the text boxes below.*** | |
| X-rays (in the past 6 months): Date:        Location: | |
| Relevant consultations:  [ ] |
| Medical history:  [ ] |
| Medication:  [ ] |
| Allergies:  [ ] |
| X-rays (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): [ ] |
| Weight (last three): [ ] |
| Blood Pressure (latest): [ ] |
| Safeguarding history:  [ ] |
| Learning disability:  [ ] |
| Use of wheelchair: [ ] |
| Accessible Information Needs (AIS): [ ] |

*The content of these forms will be reviewed as part of regular cancer auditing.*

*Contact* England.TCSTLondon@nhs.net *to report any issues with this form.*

***DO NOT*** *send referral forms with patient identifiable information to this email address.*