**Pan London Suspected Ophthalmology 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.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 from:** [ ] General Practice [ ]  Optometrist  |

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| **PLEASE DO NOT USE THIS FORM FOR THE FOLLOWING (NOT AN EYE CANCER REFERRAL):** |
| ***• Congenital hypertrophy of retinal pigment epithelium • Simple choroidal naevi, if small and flat • Conjunctival naevi • Urgent referrals for non-cancer suspected conditions******NOTE: Suspected eyelid cancers should be referred using the Urgent Suspected Skin Cancer Referral form.*** |
| 1. **REASON FOR REFERRAL – ESSENTIAL**

*See* [Pan London Suspected Ophthalmology Cancer Referral Guide](https://www.transformationpartners.nhs.uk/usc-ophthalmology-cancer-clinical-guide/) |
| ***Please record below the history and findings on physical examination and why you feel the patient may have cancer:***[ ] |
| **Important ophthalmic information to include in your description above:** |
| ***SUSPECTED DIAGNOSIS:*** *(e.g., melanoma, carcinoma, metastasis)* |
| ***AFFECTED EYE:*** *(i.e., left, right, both)* |
| ***TUMOUR LOCATION:*** *(e.g., tarsal/bulbar conjunctiva, cornea, iris, ciliary body, retina, choroid)* |
| ***TUMOUR SHAPE:*** *(nodular, diffuse, multifocal, flat, slight/prominent dome, multilobular, mushroom)* |
| ***TUMOUR DIAMETER:*** *(mm or disc diameters)* |
| ***TUMOUR FEATURES:*** *(vascularity, cysts, keratin plaque, haemorrhage, orange pigment)* |
| ***SECONDARY EFFECTS:*** *(feeder vessels, cataract, glaucoma, hard exudates, retinal detachment)* |
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| 1. **CRITERIA FOR URGENT REFERRAL – ESSENTIAL**
 |
| [ ]  **Suspected CHOROIDAL MELANOMA:** |
| [ ]  Mushroom shape[ ]  Orange pigment (lipofuscin) forming discrete clumps[ ]  Large size (i.e., tumour diameter > 4 disc diameters)[ ]  Enlargement, confirmed by sequential imaging of the tumour[ ]  Subretinal fluid, especially if causing blurred or distorted vision or photopsia (i.e., seeing a ‘ball of light’)  |
| [ ]  **Suspected OTHER INTRA-OCULAR MALIGNANCY:** |
| [ ]  Suspected intraocular metastasis if specialist ocular oncology is required[ ]  Suspected retinal lymphoma (ocular symptoms and previous CNS lymphoma, uveitis not responding to therapy)[ ]  CT / MRI showing an intraocular tumour[ ]  Retinoblastoma, if loss of red reflex in an infant or child, especially with family history of this cancer |
| [ ]  **Suspected IRIS MALIGNANCY:** |
| [ ]  Tumour is more than 5.0 mm in diameter and/or more than 1 mm thick[ ]  Diffuse tumour with indistinct margins, with or without tumour seeding onto iris surface or angle[ ]  Secondary glaucoma or cataract[ ]  Tumour involves angle, possibly with ciliary body involvement (which usually causes dilated episcleral vessels) |
| [ ]  **Suspected CONJUNCTIVAL MALIGNANCY:** |
| [ ]  Pigmented or amelanotic tumour more than 5 mm in diameter[ ]  Feeder blood vessels or visible intra-tumoural vasculature[ ]  Diffuse conjunctival and/or corneal pigmentation; thin corneal ‘frosty’ lesion(s), keratin plaque on tumour surface[ ]  Salmon pink tumour (especially in fornix or caruncular area), suggestive of lymphoma[ ]  History of recent growth, especially in adults |
| [ ]  **Suspected ORBITAL MALIGNANCY:** |
| [ ]  Proptosis or globe displacement, especially of recent onset |

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| 1. **INVESTIGATONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL**
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| [ ]  Full description of lesion (i.e., appearance and precise location) and relevant history (i.e., ocular and systemic)[ ]  Colour photograph of the suspected cancer (and any other relevant imaging, such as OCT, old photos, etc)**\***[ ]  Good explanation of problem if referral is due to clinical concerns that do not meet the above criteria.***(\*Patients with ocular symptoms should attend the optometrist in the first instance, for full eye examination and photography – this can be a colour photograph of the lesion with a phone).*** *Failure to submit adequate information and imaging will result in referral being placed on hold until missing compulsory items are requested and received.*  |

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| 1. **INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL**
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| **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**
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| 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.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** |
| [ ]  Patient added to the practice **safety-netting system** and practice will review by DDMMYY:[ ] |

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| 1. **REFERRER DETAILS**
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| Referrer: [ ]  General Practitioner/ [ ]  Optometrist | Referring clinician name: [ ] |
| Referrer Email: [ ] | Referrer Main Tel: [ ] |
| Usual GP name: [ ] | GP Practice name: [ ] |
| Usual Optometrist name: [ ] | Optometrist practice name: [ ] |
| GP Tel: [ ] | Practice bypass numbers can be found using the [NHS Service Finder website](https://servicefinder.nhs.uk/) |

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| 1. **PATIENT DETAILS**
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| 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. **CONSULTATIONS, PAST MEDICAL HISTORY, MEDICATIONS AND INVESTIGATIONS**
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| ***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: [ ]  |
| 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): [ ] |

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| *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.* |