**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 record:       | Gender Identity:       |
| Ethnicity:       |
| DOB:       | Age:       |
| Patient address:       |
| Daytime contact Tel:       **Home**:      **Mobile:**       |
| Email:       |
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| **Carer/ key worker details (if known):** |
| 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:***       |
| 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] |
| 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**
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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 (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)**
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| ***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.*** |
| Relevant consultations:       |
| Medical history:       |
| Medication:       |
| Allergies:       |
| X-rays (in the past 6 months): Date:        Location:        |
| Test results pending and Trust / Organisation performing these:       |
| 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):       |

*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.*