**Pan London Suspected Ophthalmology Cancer Referral Form**

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

|  |  |
| --- | --- |
| 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/ophthalmology) | |

|  |
| --- |
| **Referral from:** General Practice  Optometrist |

|  |  |
| --- | --- |
| **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.transformationpartnersinhealthandcare.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)* |
|  |
| 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 |

|  |
| --- |
| 1. **INVESTIGATIONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL** |
| 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.* |

|  |  |
| --- | --- |
| 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: | |

|  |
| --- |
| 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: |

|  |
| --- |
| 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)* |

|  |  |
| --- | --- |
| 1. **REFERRER DETAILS** | |
| 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 number       ***(manual entry)*** |

|  |  |
| --- | --- |
| 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: | |
|  | |
| **Carer/ key worker details:** | |
| Name: | Contact Tel: |
| Relationship to patient: |  |

|  |
| --- |
| 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 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 (latest): |
| Blood Pressure (latest): |
| Safeguarding history: |
| Learning disability: |
| Use of wheelchair: |
| Accessible Information Needs (AIS): |