**Suspected Head & Neck Cancer Two Week Wait Referral Form**

|  |  |
| --- | --- |
| **Referrer Details**  | **Patient Details**  |
| Name: | Name: | DoB: |
| Address: | Address: | Gender: |
| Hospital No.: |
| NHS No.: |
| Tel No: | Tel No. (1): | *Please check tel. nos.* |
| Tel No. (2): |
| Email: | Carer requirements (has dementia or learning difficulties)? | Capacity concerns? |
|  Decision to Refer Date: | Translator Required: Yes 🞏 No 🞏 Language……. | Mobility: |
| [ ]  | Military Service Person | [ ]  | Military Veteran | [ ]  | Member of Military Family |

|  |
| --- |
| **Level of Concern***I think it is likely that this patient has cancer, and would like the patient to be investigated further even if the first test proves negative, including a Consultant to Consultant referral if deemed appropriate. All non-site specific symptoms (e.g. iron deficiency anaemia, unexplained weight loss) are listed in the clinical details section below.***Clinical details***Please detail your conclusions and what needs to be excluded, or attach a referral letter.* |

|  |  |
| --- | --- |
| **Unexplained Neck Lump** [ ]  An unexplained palpable lump in the neck i.e. of recent onset or a previously undiagnosed lump that has changed over a period of 3 – 6 weeks.[ ]  An unexplained persistent swelling in the parotid or submandibular gland  | **Suspected Thyroid Cancer:** [ ]  unexplained thyroid lump (consider)*Please perform thyroid function test in parallel with referral.* |
| **Suspected Head and Neck Cancer – Ear, Nose and Throat Origin:** [ ]  Persistent unexplained hoarseness i.e. >3 weeks, with negative chest X-ray (consider)[ ]  An unexplained persistent sore throat especially if associated with dysphagia, hoarseness or otalgia [ ]  Referred otalgia as a symptom of laryngeal or pharyngeal malignancy[ ]  Dysphagia with obstruction in pharynx or cervical oesophagus [ ]  Persistent unilateral nasal obstruction with bloody discharge [ ]  Unexplained unilateral serous otitis media/ effusion in a patient aged over 18  | **Suspected Head and Neck Cancer – Oral Maxillo-Facial Origin** [ ]  Unexplained ulceration of the oral cavity or mass persisting for more than 3 weeks (consider)[ ]  Unexplained red and white patches (including suspected lichen planus) of the oral cavity particularly if painful, bleeding or swollen (consider).[ ]  Oral cavity and lip lesions or persistent symptoms of the oral cavity followed up for six weeks where definitive diagnosis of a benign lesion cannot be made [ ]  Non-healing extraction sockets (>4 weeks duration) or suspicious loosening of teeth, where malignancy is suspected (particularly if associated with numbness of the lip)  |
| Please note: unilateral sensorineural hearing loss is not a symptom of head and neck cancer. Please refer patients with this symptom via the normal channels.  |

|  |  |
| --- | --- |
| **Tobacco use (please specify quantity):**[ ]  **Tobacco chewing**[ ]  **Smokes a pipe**[ ]  **Smokes cigarettes**  | **WHO Performance Status:** [ ]  **0** Fully active[ ]  **1** Able to carry out light work[ ]  **2** Up & about greater than 50% of waking time[ ]  **3** Confined to bed/chair for greater than 50%[ ]  **4** Confined to bed/chair 100% |
| **Alcohol consumption (units per week)** |
| **BMI if available** |

|  |
| --- |
| Please confirm that the patient has been made aware that this is a suspected cancer referral: [ ] Yes [ ] NoPlease confirm that the patient has received the two week wait referral leaflet: [ ] Yes [ ] NoPlease provide an explanation if the above information has not been given:If your patient is found to have cancer, do you have any information which might be useful for secondary care regarding their likely reaction to the diagnosis (e.g. a history of depression or anxiety, or a recent bereavement from cancer might be relevant) or their physical, psychological or emotional readiness for further investigation and treatment? |
| Date(s) that patient is unable to attend within the next two weeks*If the patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

|  |
| --- |
| **Please attach additional clinical issues list from your practice system.****Details to include:**Current medication, significant issues, allergies, relevant family history and morbidities |

|  |
| --- |
| **Trust Specific Details** |

|  |
| --- |
| ***For hospital to complete*** UBRN: Received date: |

Please send via **ERS**