## Y:\[Graphic Files] Images Logos Clip Art\Salisbury NHS Foundation Trust RGB BLACK Feb 2017.jpgReferral for adult patients with suspected Neurological Cancer

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Sex |  |
| Date of birth |  |  |  | | |
| Address  Post Code |  | Home tel. no. |  | | |
| Work tel. no. |  | | |
| Mobile no. |  | | |

**Referral Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referring clinician |  | Preferred clinician  (if applicable) |  | | |
| GP Practice/ Department |  | New referral? |  | Re-referral? |  |
| Date of referral |  | Date last seen |  | | |
| Date of consultation |  | Dates not available |  | | |

**Communication needs**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **Symptoms :** |  | √ |
| Signs of progressive (over days or weeks) objective neurological deficit | |  |
| New onset seizures associated with progressive neurological signs  (send to first seizure clinic if no neurological signs) | |  |
| Progressive recent headache with | Papilloedema or focal neurology |  |
|  | History of relevant cancer (Breast, lung, melanoma, renal, bone) |  |
| **Please ring Neurology team to discuss if patient is deteriorating quickly or they do not fit the criteria above.** | | |  | |  |
|  |  |  |

**Short clinical history and examination (including reasons for suspecting cancer):**

**Information given to patient:**

# Please fax to: Rapid Referral Office 01722 416126

**For Office use only:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date referral received |  | Investigations required |  |
| Date of outpatient appointment |  | Time of appointment |  |