**Suspected Skin Cancer Two Week Wait Referral Form**

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| **Referrer Details** | **Patient Details** | | | | | |
| Name: | Name: | | | | DOB: | |
| Address: | Address: | | | | Gender: | |
| Hospital No.: | |
| NHS No.: | |
| Tel No: | Tel No. (1): | | | | *Please check telephone numbers* | |
| Tel No. (2): | | | |
| Email: | Carer requirements (has dementia or learning difficulties)? | | | | Capacity concerns? | |
| Decision to Refer Date: | Translator Required: YesNo Language: | | | | Mobility: | |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

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| **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.* |

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| **Refer patients to rule out suspected malignant melanoma if they have a suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more** (cross boxes and calculate total): | |
| Major features (scoring 2 points each):  change in size  irregular shape  irregular colour  **TOTAL: \_\_\_\_** | Minor features (scoring 1 point each):  largest diameter 7 mm or more  inflammation  oozing  change in sensation |
| **OR:**  dermoscopic evaluation suggests melanoma (in situ or invasive)  pigmented or non‑pigmented skin lesion / nodule that suggests nodular or amelanotic melanoma  e.g. bleeding or vascular nodule unless definite benign diagnosis | |
| **Refer patients to rule out suspected squamous cell carcinoma**  e.g. a keratoacanthoma or atypical wart, including keratotic lesions that you may think are harmless, but require a potential skin cancer diagnosis to be ruled out | |
| **Refer patients to rule out suspected basal cell carcinoma if there is particular concern that a delay may have a significant impact on a patient’s wellbeing** e.g**.** if the lesion has a diameter >2cm, or is at a difficult site, such as the tip of the nose, near the eye or upper lip, or there is either a large, infiltrative, or fast pattern of growth | |
| **Additional information**  **Where is the lesion** (Left / Right, Lower / Upper, Proximal / Distal)?  **What is the largest dimension of the lesion?**  **How long has the lesion been there?**  **Is the lesion bleeding, oozing or ulcerated?**  **What has changed** (or is change unknown)**?** | |
| **Anticoagulation and other medications that alter blood clotting (drug, indication, target INR, stability of INR).**  **Does the patient have a pacemaker or other inserted device?** | |

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| **Smoking status** | **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% |
| **BMI if available** |

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| Please confirm that the patient has been made aware that this is a suspected cancer referral: Yes No  Please confirm that the patient has received the two week wait referral leaflet: Yes No  Please 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, alcohol status and morbidities |

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| Trust Specific Details |

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

Please send via **ERS**