**Suspected Head & Neck 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 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 |

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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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| **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. | |

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| **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** |

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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.* |

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

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| **Trust Specific Details** |

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

Please send via **ERS**