## 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 |       |  |  |
| AddressPost 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**

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| --- |
|  |
| **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 |       |