**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: 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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| **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 melanomae.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 [ ] 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, 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**