Suspected Cancer In Adults (2ww)
GDC Number:

NHS Northern Cancer Alliance

Date of Referral:

Name		**DOB**		**NHS No**	

Send this form by Secure Email (or Fax)

- ☐ Patient has been informed that this is an urgent referral for suspected cancer
- ☐ The patient is available and willing to attend hospital for tests/appointment within 14 days
- ☐ The patient has been given the 2WW patient information leaflet

Hyperlinks to: **NICE GUIDANCE** **2WW Patient Information Leaflet**

NICE Guidance

SITE of LESION:

ENT	
☐	Patients over 45 with persistent (not intermittent or fluctuating), unexplained hoarseness
☐	Persistent, unexplained lump in the neck or parotid region of recent onset. (It is advisable to wait 3 weeks after an upper respiratory tract infection for reactive lymph nodes to improve)
☐	Unexplained, persistent, unilateral enlargement or ulceration of the tonsil or adjacent soft palate
ORAL & MAXILLOFACIAL	
☐	Unexplained ulceration or lump on the lips or in the oral cavity lasting more than 3 weeks
☐	Persistent, unexplained lump in the neck or parotid region of recent onset
☐	New unexplained red or red and white patch in oral cavity consistent with Erythroplakia /erythroleukoplakia; lasting more than 3 weeks and having been present less than six months.

NOT TO BE USED FOR THE FOLLOWING:
Toothache or Dental Infection
or
Delayed and Unexplained Non-Healing of a Dental Socket of less than 3 weeks

Reason for Referral – Compulsory*

Social context

Alcohol consumption

Smoking history

Name		DOB		NHS No	

Performance Status			
	☐	0	Fully active
	☐	1	Cannot carry out heavy physical work
	☐	2	Up and about more than half the day and can look after yourself
	☐	3	In bed or sitting in a chair for more than half the day and need help in looking after yourself
	☐	4	In bed or a chair all the time and need a lot of looking after

Please indicate COVID 19 risk:		
☐	**Standard**	No co-morbidities
☐	**Vulnerable**	Co-morbidities/frailty
☐	**Shielded**	In the shielded group because of high risk from COVID 19 infection

Significant Past Medical History

Prescribed Medication

Any known Allergies

Non-therapeutic drug use

Any known risk to others

Please complete the rest of this form

Referrer details

Name of Referrer:		Dentist Surgery Address:
Dentist surgery Telephone number:		
Dentist surgery e-mail address		

GP Details

Usual GP:		GP Address:
GP surgery Telephone number:		
GP surgery email address		

Patient details

Name:		Address:
Gender:		
DOB & Age		
NHS Number:		
Home Tel No		**Contact Consent** (NB: not all services use texts or emails as method of communication) please select:
Mobile No:		☐ Can leave a message on answer machine
Email address:		☐ can contacted by text
Work Tel No		☐ can contacted by email
Carer/Advocate:	**The patient has confirmed the following person should be included in correspondence**: Name: Contact details:	
Ethnicity:		
Interpreter:	☐ **Yes** Language:	
Accessibility Needs:	☐ Wheelchair access ☐ Deaf ☐ Registered Blind ☐ Learning Disability ☐ Other disability needing consideration ☐ Accompanied by Carer	
Risks:	☐ Vulnerable Adult Any other known risk:	
Other	☐ Military Veteran	

To be completed by the Data Team (Insert Dates)

Received: / / First Appointment booked: / /
First Appointment date: / / 1st seen: / /
Specify reason if not seen on 1st appointment:
Diagnosis: Malignant ☐ Benign ☐