SOUTH WEST LONDON CANCER NETWORK: SUSPECTED CHILDREN'S CANCERS REFERRAL FORM

URGENT REFERRALS CRITERIA

(Please tick box)

Symptoms:

- Fatigue/malaise/lethargy ☐
- Bone pain ☐
- Headache ☐
- Behavioural change ☐
- Deterioration in school performance ☐
- Haematuria ☐

Examination:

- Fever ☐
- Lymphadenopathy ☐
- Hepatomegaly ☐
- Splenomegaly ☐
- Abnormal Blood Count ☐
- Soft tissue mass ☐
- Abdominal mass ☐
- Neurological signs ☐
- Petechiae/Purpura ☐
- Details

Other:

Date of GP decision to refer: **No. of pages faxed:**

GP DETAILS

GP Name and Initials: **GP Practice Code:**

Address *(use practice stamp if available)*: **Post Code:**

Telephone No: **Fax. No:**

PATIENT DETAILS

Last Name: **First Name:**

Address: **Post Code:**

Daytime Telephone No: **Date of Birth:** **Age:**

Has the patient previously visited this hospital? Y/N **Gender: M** ☐ **F** ☐

Hospital No (if known): **NHS No:**

Interpreter required? Y/N: **First Language:**

COMMENTS/OTHER REASONS FOR URGENT REFERRAL

What have the parents been told:

TO BE COMPLETED BY THE DATA TEAM:

Date received: Date 1st appointment booked: Date of 1st appointment: Date 1st seen:

Specifiy reason if not seen at 1st appointment offered: Final diagnosis (please circle): Malignant Benign