SOUTH WEST LONDON CANCER NETWORK: SUSPECTED HEAD & NECK CANCERS REFERRAL FORM

URGENT REFERRALS CRITERIA

(Please tick box)

Risk factors:

- Smoker or betel nut chewer ☐
- Alcohol Misuse ☐

Key symptoms: if duration less than one month please explain in comments box why referral is urgent

- Pain on swallowing ☐
- Sore throat ☐
- Lump in neck ☐
- Hoarseness ☐
- Dysphagia (food or liquid) ☐
- Persistent ulcer in mouth ☐

Other symptoms: please explain in Comments box why these constitute an urgent referral

- Unilateral ear pain or deafness ☐
- Unilateral nasal obstruction ☐
- Isolated cranial neuropathy ☐
- Unexplained tooth mobility ☐

Clinical Examination

- Oral ulceration/tumour ☐
- Thyroid or salivary mass ☐
- Lump in neck ☐
- Orbital mass ☐

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

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

August 2003