SOUTH WEST LONDON CANCER NETWORK: SUSPECTED SARCOMAS REFERRAL FORM

URGENT REFERRALS CRITERIA

(Please tick box)

Suspected diagnoses:

Soft Tissue sarcoma ☐

Primary bone tumour ☐

History:

Duration of symptoms (months) ....

Location ....

Swelling ☐

Pain ☐

Increase in size ☐

Clinical Examination:

Size .... cms

Deep to Fascia ☐

Skin Involvement ☐

Radiology:

Done Yes ☐ No ☐

Suspicious of bone tumour Yes ☐ No ☐

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