**SUSPECTED BRAIN + CENTRAL NERVOUS SYSTEM CANCER REFERRAL FORM**

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| **Referrer Details**  | **Patient Details**  |
| Name: **Free Text Prompt**       | Forename:**Given Name**  | Surname:**Surname**  | DOB: **Date of Birth**  |
| Address:**Organisation Full Address (stacked)**  | Address:**Home Full Address (stacked)**  | Gender: **Gender(full)**  |
| Hospital No: **Hospital Number**  |
| NHS No: **NHS Number**  |
| Tel No:**Organisation Telephone Number**  | Tel No. (1): **Patient Home Telephone**  | *Please check telephone numbers* |
| Tel No. (2): **Patient Mobile Telephone**  |
| Email:**Organisation E-mail Address**  | Carer requirements (has dementia or learning difficulties)?[ ]  Yes [ ]  No  | Does the patient have the capacity to consent?[ ]  Yes [ ]  No  |
| Decision to Refer Date:**Short date letter merged**  | Translator Required: [ ]  Yes [ ]  No Language:       | Mobility:       |

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| **Referral criteria:**Only patients with the following symptoms can be referred on the 2ww:[ ]  New and / or progressive neurological deficit, with or without cranial nerve palsies (please note that deafness alone cannot be defined as a neurological deficit)[ ] Headaches with other features of raised intracranial pressure (ICP), such as headache worse on waking, associated with vomiting, with or without papilloedema[ ]  Previous history of cancer with unresolved headaches |

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| **Clinical Details** Please provide any relevant history related to cancer along with presenting symptoms.(Including Clinical examination (in particular neurological examination, visual fields and fundoscopy)*Please detail your conclusions and what needs to be excluded, or attach referral letter.*     In addition to this requesters are asked the following questions when requesting an MRI on ICE:* Does this patient have an aneurysm clip? If there is any bout please select ‘yes’ [ ]  Yes [ ]  No
* Does this patient have a cardiac pacemaker? [ ]  Yes [ ]  No
* Does this patient have a metallic foreign body in their eye? Is there a history of injury that makes this possible? [ ]  Yes [ ]  No
* Does this patient have any other metallic foreign body or surgical implant? [ ]  Yes [ ]  No
* Is there a possibility that this patient is pregnant? [ ]  Yes [ ]  No

If the requestor answers ‘yes’ to any of those questions then they are asked to provide further information or to seek advice from imaging:       |

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| **Is the patient on anticoagulants and or anti-platelet agents?** [ ]  Yes [ ]  NoIf ‘yes’ please provide details:       | **Glasgow Coma Score:**      (If under 15 please consider admission) |
| **Smoking status****Smoking**  | **WHO Performance Status:** [ ]  **0** Fully active[ ]  **1** Able to carry out light work[ ]  **2** Up and 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****BMI**  |
| **Mobility:**       |

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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 is aware of the nature of the referral, consider seeing again to reassess symptoms and refer when willing and able to accept an appointment.* |

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| **Please attach additional clinical issues list from your practice system****Details to include:**Current medication, significant issues, allergies, relevant family history, alcohol status and morbiditiesMedication Problems Allergies Family History Alcohol Consumption  |

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| **Trust Specific Details**The Neuro-oncology Team is based at NBT.**Please note that patients with a new onset of seizures, both partial and generalized tonic-clonic (GTC), should be referred to the *First Fit Clinic*, details of which can be found** [**here**](https://www.nbt.nhs.uk/clinicians/services-referral/neurology-clinicians). |

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| ***For hospital to complete*** UBRN: Received date: |