**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  No  If ‘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 No  Please confirm that the patient has received the two week wait referral leaflet: Yes No  Please 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 morbidities  Medication  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: |