SUSPECTED BRAIN & CNS CANCER REFERRAL FORM

Press the <Ctrl> key while you click here to VIEW REFERRAL GUIDELINES

REFERRAL DATE:

For Choose and Book referrals, attach this template to a referral in Choose and Book within 24 hours of creating the request - an appointment must be made for the patient before they leave the practice.

Press the <Ctrl> key while you click here to VIEW LEAD CLINICIAN CONTACT INFORMATION

Please X the corresponding box for the hospital the referral is being made to and fax/send within 24 hours.

Hospital	Phone	Fax	Email: select & copy OR <Ctrl>+click
☐ Barnet	0208 370 9079	020 8375 1977	RF-tr.bcf2weekwaitreferrals@nhs.net
☐ Barts & London	020 7767 3333	020 3594 3278	
☐ BHRUT	01708 435 065	01708 435 074/367	
☐ Chase Farm	0208 370 9079	020 8375 1977	RF-tr.bcf2weekwaitreferrals@nhs.net
☐ Homerton	020 8510 5099	020 8510 7832	cancerreferrals@homerton.nhs.net
☐ Newham	020 7363 8817	020 7363 8818	
☐ North Middlesex	020 8887 2661/2662/3390	020 8887 2663	Northmid.2weekwaitteam@NHS.net
☐ Princess Alexandra	01279 827 550	01279 827 171	tpa-tr.FastTrackReferrals@nhs.net
☐ Royal Free	020 7433 2973/4	020 7433 2950/1	
☐ UCLH	020 3447 9599	020 3447 9932	uclh.2ww@nhs.net
☐ Whipps Cross	020 8535 6856	020 8928 8836	
☐ Whittington	020 7288 3736/3542	020 7288 5621	twowwbookings.whitthealth@nhs.net

☐ **Patient has previously visited selected hospital** **HOSPITAL No:**

PATIENT DETAILS
SURNAME: **FIRST NAME:** **TITLE:**
GENDER: **DOB:** **NHS NO:**
ETHNICITY: **LANGUAGE:**
☐ **INTERPRETER REQUIRED** ☐ **TRANSPORT REQUIRED**
PATIENT ADDRESS: **POSTCODE:**
DAYTIME CONTACT☏:
HOME☏: **MOBILE☏:** **WORK☏:**
EMAIL:

GP DETAILS
USUAL GP NAME:
PRACTICE NAME: **PRACTICE CODE:**
PRACTICE ADDRESS:
BYPASS☏:
MAIN☏: **FAX:** **EMAIL:**
REFERRING CLINICIAN:

DOB: NHS no:

CLINICAL DETAILS

NEUROLOGICAL DEFICIT

- ☐ **Sub-acute (over days to weeks)**
- ☐ **Progressive - including personality or behaviour change in the absence of previously diagnosed or alternative neurological illness**

SEIZURES

New onset seizures characterised by one or more of the following:

- ☐ **Significant post-ictal focal deficit (excluding confusion)**
- ☐ **Focal seizures (e.g. jerking of one limb, temporal lobe auras)**
- ☐ **Associated inter-ictal focal deficit**

HEADACHE

Note: Evidence suggests intermittent headache with morning vomiting is very rarely associated with brain tumours. If in doubt, discuss with on-call neurological or neurosurgical registrar
Press the <Ctrl> key while you click here to VIEW CONTACT DETAILS

- ☐ **New onset headache with associated focal neurology**
- ☐ **New onset daily headache, less than 4 weeks duration, with features suggestive of raised intracranial pressure e.g. papilloedema, morning vomiting or double vision**

Short history emphasising your concerns:

Any symptoms or signs not covered by the guidelines:

Duration of symptoms:

Family history of cancer including age at diagnosis:

- ☐ **I confirm that I have discussed with the patient the possibility that the diagnosis may be cancer and that they may be invited to come directly for blood tests, an X-ray test or endoscopic procedure and be asked to complete a form on-line, over the telephone or to come to a clinic**
- ☐ **I confirm that I have explained the two week wait appointment process to the patient**

Please hand the patient a copy of the URGENT REFERRALS PATIENT INFORMATION LEAFLET
Press the <Ctrl> key while you click here to view the leaflet

ESR

CRP

LFT

Bone profile

Serum Calcium

IMAGING STUDIES **Please include date:** **and location:**

Problems

Allergies

Medication