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| **URGENT SUSPECTED CANCER REFERRAL FORM****SUSPECTED CHILDREN’S CANCERS**  |
| **Please refer to \*CMCA Urgent Suspected Cancer Pathways for Children and Young People**As per NICE guidance referrals may be Immediate, Very Urgent (48 hours) or Urgent (2 weeks)**Please refer to local guidance on route of referral** **If suspicion of leukaemia - follow immediate referral guidance by telephone to on call AHCH oncologist via switchboard 0151 2284811**For guidance on urgency of referral, consider telephone conversation with local paediatric consultant or on call oncologist, AHCH. Written guidance can be found: * [NICE NG12 Referral guidance for suspected childhood cancers](https://www.nice.org.uk/guidance/ng12/chapter/Recommendations-organised-by-site-of-cancer#childhood-cancers)
* [cclg-referral-guidance-april-2021.pdf](https://www.cclg.org.uk/sites/default/files/2025-02/cclg-referral-guidance-april-2021.pdf)
* Urgent Suspected Cancer Pathways for Children and Young People, CMCA, 2025
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| **PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD** |
| Has the patient, parent or guardian been counselled they are being referred to a suspected cancer service and the reason for referral? [NICE ng12 guidance/ patient support](https://www.nice.org.uk/guidance/ng12/chapter/Recommendations-on-patient-support-safety-netting-and-the-diagnostic-process#patient-information-and-support)Single Code Entry: Informed of reason for referral... | Yes  No   |
| Has the patient, parent or guardian been given relevant written information about this referral?Single Code Entry: Provision of written information about 2 week wait referral  | Yes  No   |
| Is the patient available within the next 48 hrs /14 days? \*If selected no, please explain why?  | Yes  No   |
| Have you checked all contact details are correct and informed that the initial appointment may be by telephone? | Yes  No   |
| **REFERRER DETAILS** |
| Referring GP | Free Text Prompt  | GP Code | Usual GP Organisation National Practice Code  |
| Usual GP | Usual GP Title Usual GP Forenames Usual GP Surname  |
| GP Address  | Usual GP Full Address (single line)  |
| GP Tel. No.  | Usual GP Phone Number  |
| GP secure email | Organisation E-mail Address  |
| Date seen by GP | Long date letter merged  | Decision to refer date | Long date letter merged  |
| **PATIENT DETAILS** |
| Title & Surname | Title Surname  | Forename(s) | Given Name  |
| Date of Birth | Date of Birth  | Age | Age  | Gender | Gender(full)  |
| Address | Home Full Address (single line)  |
| Home Tel No. | Patient Home Telephone  | Work Tel No. | Patient Work Telephone |
| Mobile Tel No. | Patient Mobile Telephone | Patient email | Patient E-mail Address  |
| Parent / Guardian  | NameContact Telephone Relationship  | Single Code Entry: Patient's next of kinFree Text PromptFree Text Prompt |
| **REFERRAL INFORMATION** |
| **Main reason for referral (**please explain why you think this child may have cancer )Free Text Prompt  |
| **Please refer to Urgent Suspected Cancer Pathways for Children and Young People for fuller details** |
| Please Indicate with X type of Cancer suspected | Please add additional information of symptoms and/or signs |
| **Abdominal Tumour**Palpable abdominal mass or abdominal distension - Very urgent |    |  |
| **Leukaemia-** Pallor, fatigue, bruising, petechiae, hepatosplenomegaly - Immediate |  |  |
| **Lymphoma**Enlarged lymph nodes fitting the criteria for referral - Urgent |  |  |
| **Bone Tumour**Chronic pain, palpable mass - Urgent |  |  |
| **Soft Tissue Sarcoma**Soft tissue mass lesion - Urgent |  |  |
| **Retinoblastoma** Absent red reflex - Urgent  |    |  |
| **Brain or spinal tumour**Symptoms of raised intracranial pressure, new squint - Immediate |  |  |
| **Skin Cancer**Urgent |  |  |
| **Breast**Meeting criteria for urgent suspected cancer referral - Urgent |  |  |
| **Thyroid**Urgent |  |  |
| **Not sure / Other** (please state)  |   |  |
| **Symptoms** |  | **Detail of symptoms/Length of time** |
| Fatigue/malaise/lethargy  |   | Single Code Entry: Fatigue...  |
| Unexplained Bone pain  |   | Single Code Entry: Bone pain...  |
| Headache |   | Single Code Entry: Headache  |
| Vomiting/seizures  |   | Single Code Entry: Vomiting...  |
| Behavioural change  |   | Single Code Entry: Normal behaviour...  |
| Deterioration in school performance |   | Single Code Entry: Deterioration in school performance  |
| Unexplained visible haematuria  |   | Single Code Entry: Frank haematuria...  |
| Ophthalmologic – absent red reflex  |   | Single Code Entry: Red reflex...  |
| Weight loss  |   | Single Code Entry: Abnormal weight loss...  |
| Fever |   | Single Code Entry: Fever  |
| Night sweats |   | Single Code Entry: Night sweats  |
| Persistent Infection  |   | Single Code Entry: Persistent infection  |
| Unexplained bruising |   | Single Code Entry: Bruising symptom  |
| Unexplained bleeding  |   |  |
| Newly abnormal cerebellar or other neurological function  |   | Single Code Entry: Neurological symptom changes...  |
| Shortness of breath  |   | Single Code Entry: Dyspnoea  |
| Pruritus  |   | Single Code Entry: Pruritus  |
| Unexplained bone swelling |   | Single Code Entry: O/E - bone abnormality  |
| Other symptoms  |   |  |
| **Examination**  | **Details** |
| Lymphadenopathy  |   | Single Code Entry: Lymphadenopathy  |
| Soft tissue mass  |   | Single Code Entry: O/E - soft tissue swelling  |
| Fever  |   | Single Code Entry: Tympanic temperature  |
| Abdominal Mass |   | Single Code Entry: Abdominal mass  |
| Hepatomegaly |   | Single Code Entry: Hepatomegaly  |
| Splenomegaly |   | Single Code Entry: Splenomegaly  |
| Pallor/signs of anaemia  |   | Single Code Entry: O/E - colour pale...  |
| Neurological signs |   |   |
| Bruising |   | Single Code Entry: O/E - bruising  |
| Other Exam findings  |   |  |
| **INVESTIGATIONS Bloods CXR**Please attach if no merged information is pulled  |
| Investigations  |
| **CULTURAL, MOBILITY STATUS AND ASSISTANCE REQUIREMENTS** |
| Does the patient have any Communication, Mobility or Safeguarding needs  | Yes  No   |
| **Please detail if there are any reasonable adjustments needed or additional requirements** | Free Text Prompt  |
| If the patient requires Translation or Interpretation Services **Please give details**: |  |
| What is the patient’s preferred first language? | Main Language  |
| Ethnicity | Ethnic Origin  |
| Religion (if recorded) | Religion  |
| Temporary resident | Yes  No   |
| Overseas visitor  | Yes  No   |
| **CLINICAL INFORMATION/HISTORY** |
| Consultations |
| Problems  |
| Values and Investigations  |
| Medication  |
| Allergies  |