**URGENT REFERRAL FOR SUSPECTED SKIN CANCER**

If you wish to include an accompanying letter, please do so.

**DO NOT USE THIS FORM FOR SUSPECTED BCC**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer 2015.

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| **Patient Details** | **GP Details**  |
| Name: |  | Name: |  |
| Address: |  | Address: |  |
| Phone No:  |  |
| NHS Number: |  | Fax No: |  |
| Hospital Number: |  | Name of Referrer: |  |
| Date of Birth: |  | Decision to refer date:  |  |
| Interpreter/Sign Language required: | [ ]  Yes [ ]  No | Language: |  |
| Contact No (next 48 hours): | Home: |  | Work: |  | Mobile:  |  |
| [ ]  Patient consents to receiving information via text message on their mobile. |
| **GP Declaration – Please confirm and tick**[ ]  I have informed the patient they have symptoms/lesions which may be caused by skin cancer, that they are being referred to the rapid access suspected cancer clinic, and the nature of the tests likely to take place. [ ]  I have informed my patient that if they are suitable for the Teledermatology pathway they will see a clinical photographer initially, following which a Consultant Dermatologist will review their images and inform them of any next steps by post or telephone.[ ]  I have provided the patient with a 2 week wait information leaflet.[ ]  My patient has confirmed they are available to attend within 2 weeks. [ ]  My patient is aware that they will be offered the first available appointment at any one of our hospitals (Queen Elizabeth,  Heartlands, Solihull or Good Hope Hospital)  |
| **Please complete to allow UHB to identify suitability for patient to go straight to photography (Teledermatology):** |
| Can the lesion(s) be clearly seen and photographed? | [ ]  Yes [ ]  No | Is the lesion open or scabbed?  | [ ]  Yes [ ]  No |
| More than two suspected skin cancers? | [ ]  Yes [ ]  No | Does the lesion require redressing by a health professional? | [ ]  Yes [ ]  No  |
| Is the lesion on the patient’s genitals? | [ ]  Yes [ ]  No |
| Is the patient able to mobilise safely (with any personal walking aids) and manage their toilet needs? | [ ]  Yes [ ]  No | Does the patient require transport?  | [ ]  Yes [ ]  No |
| **Suspected Diagnosis:** (Check relevant boxes)Use the following 7-point checklist for pigmented skin lesions:**Melanoma:** [ ] Location: ………………………………………….Size of lesion: …………………………………..**Major features: (2 points each)**Change in size [ ] Irregular shape [ ] Irregular colour[ ] **Minor feature: (1 point each)**Largest diameter 7mm or more [ ] Inflammation [ ] Oozing [ ] Change in sensation [ ]  | **Squamous cell carcinoma:** [ ] Location: …………………………………Size of lesion: …………………………..**Characteristics:**Non-healing Keratinizing [ ] Crusted with significant induration [ ]  Documented expansion over 8 weeks [ ] New/growing cutaneous lesion [ ] Histological diagnosis of SCC [ ] Include histology report with referral**Risk factors:**Immunosuppression [ ]  |
| Comments: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….. |
| **Clinical Details:** History/Examination/Investigations……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..Medication ………………………………………………………………………………………………………………………………………………... |
| **PATIENT MEDICAL DATA:****Comorbidities:****Any allergies/anticoagulation’s:****BMI:**  |
| **Accessibility Needs:**[ ]  Wheelchair access[ ]  Deaf[ ]  Registered blind[ ]  Learning Disability[ ]  Other disability needing consideration[ ]  Accompanied by carer | **WHO Performance Status:**[ ]  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% |

**Please be aware that forms that contain missing data or are incorrectly completed will be returned to the Practice for correction and resubmission.**