

Date of Referral: **Short date letter merged**

Name	Full Name	DOB	Date of Birth	NHS No	NHS Number
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Attach this form to the e-referral within 24 hours

If the ERS not available, then send this form AND 'Referral header sheet' by secure email or FAX

- Patient has been informed that this is an urgent referral for suspected cancer
- The patient is available and willing to attend hospital for tests/appointment within 14 days
- The patient has been given the 2WW patient information leaflet

Hyperinks to: [NICE GUIDANCE](#) [Patient info leaflet including easy read](#)

NICE Guidance	SITE of LESION: Free Text Prompt
	ENT
	<input type="checkbox"/> Patients over 45 with persistent (not intermittent or fluctuating), unexplained hoarseness
	<input type="checkbox"/> Persistent, unexplained lump in the neck or parotid region of recent onset. (It is advisable to wait 3 weeks after an upper respiratory tract infection for reactive lymph nodes to improve)
	<input type="checkbox"/> Unexplained, persistent, unilateral enlargement or ulceration of the tonsil or adjacent soft palate
	ORAL & MAXILLOFACIAL
	<input type="checkbox"/> Unexplained ulceration or lump on the lips or in the oral cavity lasting more than 3 weeks
	<input type="checkbox"/> Persistent, unexplained lump in the neck or parotid region of recent onset
	<input type="checkbox"/> New unexplained red or red and white patch in oral cavity consistent with erythroplakia/erythroleukoplakia; lasting more than 3 weeks and having been present less than six months.
	NOT TO BE USED FOR THE FOLLOWING: Toothache or Dental Infection OR Delayed and Unexplained Non-Healing of a Dental Socket of less than 3 weeks
Consider an urgent referral to head and neck for these symptoms not covered by NICE guidelines (for an appointment within 6 weeks). DO NOT USE THIS FORM	
Persistent, upper dysphagia (may be triaged to 2WW if associated with pain on swallowing, and/or pain radiating to the same side ear, and weight loss – please give this information in the reason for referral)	
Unexplained persistent sore throat	
Unexplained unilateral nasal obstruction when associated with blood-stained discharge and /or unilateral facial swelling	
Delayed and unexplained non-healing of a dental extraction socket for over 3 weeks	

Reason for Referral – Compulsory*

WEIGHT: Single Code Entry: O/E - weight Single Code Entry: O/E - weight Single Code Entry: O/E - weight

Title Given Name Surname

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Performance Status	<input type="checkbox"/>	0	Fully active
	<input type="checkbox"/>	1	Cannot carry out heavy physical work
	<input type="checkbox"/>	2	Up and about more than half the day and can look after yourself
	<input type="checkbox"/>	3	In bed or sitting in a chair for more than half the day and need help in looking after yourself
	<input type="checkbox"/>	4	In bed or a chair all the time and need a lot of looking after

Please indicate COVID 19 risk:		
<input type="checkbox"/>	Standard	No co-morbidities
<input type="checkbox"/>	Vulnerable	Co-morbidities/frailty
<input type="checkbox"/>	Shielded	In the shielded group because of high risk from COVID 19 infection

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Referrer details

Name of Referrer: <input type="text"/>	Date of Referral: <input type="text"/>	Short date letter merged
Referring organisation Organisation Name , Organisation Full Address (single line) Tel: Organisation Telephone Number Email: Organisation E-mail Address Fax: Organisation Fax Number		GP details Usual GP Full Name Usual GP Organisation Name, Usual GP Full Address (single line) Tel: Usual GP Phone Number Fax: Usual GP Fax Number
Name of GP to address correspondence to, if different to accountable GP		<input type="text"/>

Patient details

Name	Full Name	Address:	Home Full Address (stacked)	
Gender	Gender(full)			
DOB & Age	Date of Birth Age: Age			
NHS Number:	NHS Number			
Patient Contacts	Home:	Patient Home Telephone	Mobile:	Patient Mobile Telephone
	Work:	Patient Work Telephone	Email:	Patient E-mail Address
	Carer/Advocate: The patient has confirmed the following person should be included in correspondence – Name: <input type="text"/> Contact Details: <input type="text"/>			
Contact Consent:	<input type="checkbox"/> Can leave message on answer machine <input type="checkbox"/> Can contact by text <input type="checkbox"/> Can contact by Email		NB: Not all services use Texts or Emails as a method of communication.	
Ethnicity:	Ethnic Origin			
Interpreter:	<input type="checkbox"/> Yes Language: Single Code Entry: Main spoken language <input type="text"/>			
Accessibility Needs:	<input type="checkbox"/> Wheelchair access <input type="checkbox"/> Deaf Single Code Entry: Deafness <input type="checkbox"/> Registered Blind Single Code Entry: Registered blind <input type="checkbox"/> Learning Disability Single Code Entry: On learning disability register Single Code Entry: [X]Specific developmental disorders of scholastic skills <input type="checkbox"/> Other disability needing consideration <input type="text"/> <input type="checkbox"/> Accompanied by Carer			
Risks:	<input type="checkbox"/> Vulnerable Adult (detail below if any recording within last 3 years) Single Code Entry: Vulnerable adult Single Code Entry: Adult no longer vulnerable Single Code Entry: Failed or difficult intubation Any other known risk: <input type="text"/>			
Other:	Single Code Entry: Military veteran Single Code Entry: Left military service Single Code Entry: History relating to military service Single Code Entry: Occupation history Single Code Entry: Has a carer Single Code Entry: Is no longer a carer Single Code Entry: Is a carer Single Code Entry: Carer			

Patient accessible information

Communication support: Uses a legal advocate...

Professional required: Interpreter needed - British Sign Language...

Contact method: Requires contact by telephone...

Information format: Requires information verbally...

[If you have any problem with this form or suggested changes, please contact & click here to open direct email.](#)

NB: NOT TO BE USED FOR REFERRING A PATIENT 2WW NE Head and Neck Referral Form EMIS Web V7 Gateshead April 2018

To be completed by the Data Team (Insert Dates)Received: / / **First Appointment booked:** / /**First Appointment date:** / / **1st seen:** / /

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Specify reason if not seen on 1st appointment:

Diagnosis: Malignant **Benign**