**Suspected Brain & CNS Cancer Referral Form**

**Patients would usually be referred for MRI in the first instance although there may be a small number of exceptions where MRI imagining before referral is not appropriate. In these instances please refer using this form explaining the situation.**

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| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS Number: | |
| Telephone Numbers  **Please check tel nos with patient** | Tel No (Home): | Tel No (work): | Tel No (Mobile): |
| **GP Details** | | | |
| Referring GP: | | GP Tel No: | |
| Practice Name: | | Practice Email Address: | |
| Practice Address: | | Date of decision to refer: | |

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| **Patient Information** | | | |
| Does your patient have a learning disability? | | | Yes No |
| Is your patient able to give informed consent? | | | Yes No |
| Is your patient fit for day case investigation? | | | Yes No |
| If a translator is required, please specify language: | | | |
| Is patient on any of the following medications? | | | |
| Aspirin | YesNo | Indication for therapy: | |
| Clopidogrel /Prasugrel etc . | Yes No | Indication for therapy: | |
| Warfarin | Yes No | Indication for therapy: | |
| NOAC (Rivaroxaban etc.) | Yes No | Indication for therapy: | |
| Insulin | Yes No |  | |

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| It would be helpful if you could provide performance status information (please tick as appropriate)  Fully active  Able to carry out light work  Up & about 50% of waking time  Limited to self-care, confined to bed/chair 50%  No self-care, confined to bed/chair 100% |

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| Please confirm that the patient is aware that this is a suspected cancer referral: Yes No |
| Date(s) that patient is unable to attend within the next two weeks:  *If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |

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| **Level of Cancer Concern** (completion optional) |
| **All patients should meet NICE guidelines for suspected cancer 2015**  *“I’m very concerned that my patient has cancer”*  *“I’m unsure, it might well be cancer but there are other equally plausible explanations.”*  *“I don’t think it likely that my patient has cancer but they meet the guidelines.”*  **Reasons for referring**  *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* |

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| ***Referral Criteria*** |
| **GPs are now able to request Brain MRI for adults with progressive, sub-acute loss of central neurological function.** Order Brain MRI via the usual local imaging request methods (electronic or pink card etc). Patients who have concerning findings described in the radiology report should be informed and, when appropriate, referred to their local hospital using this suspected cancer form to provide the clinical picture. Patients would usually be referred for MRI in the first instance although there may be a small number of exceptions where MRI imagining **before** referral is not appropriate. In these instances please refer using this form explaining the situation. |
| **Please highlight the concerning symptoms:**  **Headache** - new, non-migrainous, with features suggestive of raised intercranial pressure (please select all that apply)  Qualitatively different unexplained headache becoming progressively more severe  vomiting  drowsiness  posture related headache  pulse-related tinnitus  **Other neurological symptoms**  blackout  personality change  unexplained memory problems  **seizures** (>1 attack of recent onset)  **progressive cognitive impairment, behavioural disturbance**  subacute progressive focal neurological deficit. Please describe:  slowness or combination of these of recent onset. Please describe:  Are the above symptoms:  de novo or  other primary cancer site –specify: |

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| **Clinical Summary** |
| **Clinical History (significant past and current medical history):** |
| **Current medication:** |
| **Blood Tests (if available – last 3 months):** |
| **Allergies:** |
| **Smoking:** |
| **BMI** (if available): |
| **Alcohol** (if available)**:** |

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| **For hospital to complete** UBRN:  Received Date: |