**Suspected Skin Cancer Referral Form**

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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? | | | YesNo |
| Is your patient able to give informed consent? | | | YesNo |
| Is your patient fit for day case investigation? | | | YesNo |
| 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 select 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 |  |
| Please indicate your level of cancer concern: | | | | Low |  | Medium | |  | High | |  |
| 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.* | | | | | | | | | | | |
| **REASONS FOR REFERRAL** | | | | | | | | | | | |
| **All patients should meet NICE guidelines for suspected cancer 2015**  **Please detail your reasons for referring, presenting symptoms and your examination findings** | | | | | | | | | | | |
| **IN ALL CASES PLEASE GIVE THE NUMBER OF LESIONS OF CONCERN** | | | | | | | | | | | |
| **1 Lesion** |  | **2 Lesions** |  | | | | | **>2 Lesions** | | |  |
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| **Malignant Melanoma** | | | | |
|  | Dermoscopy suggests melanoma of the skin | | | |
|  | Pigmented or non‑pigmented skin lesion that suggests nodular melanoma e.g. bleeding or vascular nodule unless definite benign diagnosis | | | |
|  | Suspicious pigmented skin lesion with a weighted 7 point checklist score of 3 or more: | | | |
| Major features (scoring 2 points each): | | | Minor features (scoring 1 point each): | |
|  | Change in size | | Largest diameter 7 mm or more |  |
|  | Irregular shape | | Inflammation |  |
|  | Irregular colour | | Oozing |  |
|  | |  | Change in sensation |  |

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| **Squamous cell carcinoma** | | | |
| Skin lesion that raises the suspicion of squamous cell carcinoma or where SCC is in your differential diagnosis (eg keratoacanthoma or atypical wart) | | | |
| **Location** | Upper Arm | | scalp / face |
| Forearm | | Trunk |
| Dorsum of hand | | Lower Leg |
| Finger | |
| **Size** | **Smaller than 1.5cm diameter** | | **Larger than 1.5cm diameter** |
| **What is the largest dimension? :** |  | |

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| **Basal cell carcinoma**  Only high-risk BCC requires assessment via a suspected cancer pathway. **It is essential that the referrer provides the following information to facilitate triage.** Lesions that are lower risk may be seen via a different urgent pathway, and the referrer delegates responsibility to the specialist team to make this decision. | | | | | | | | |
| **Lesion Size:** | 0-10mm |  | 10-20mm |  | | >20mm | |  |
| **Border** | Well defined | | |  | Poorly Defined | | |  |
| **Location:**  ‘ | Mask areas on face(central face, periorbital, eyebrows, nose, lips, chin, mandible, preauricular, postauricular, temple, ears) | | |  | Other areas on face | | |  |
| Hands, Nail folds, Genitals, pretibial, ankles, feet | | |  | Trunk and other locations on extremities | | |  |
| **Immunosuppressed** | Yes |  | | | | | No |  |
| **At site of previous radiotherapy** | Yes |  | | | | | No |  |
| **This is a recurrence** | Yes |  | | | | | No |  |

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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)**:** |
| **Most recent blood pressure:**       / |
| **Most recent HbA1c:** |

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