**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?  | [ ]  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  | [ ] Yes[ ] No  | 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:  |