Hull and East Yorkshire Hospitals NHS
NHS Trust

High Risk Of Cancer

2 WEEK WAIT

Referral for suspected BRAIN CANCER

Please complete all sections and Fax to: 01482 675505
The Central Referral Point Telephone Number is: 01482 604308

Patient Details			GP Details	
Name			Name	
DoB			Practice Code	
Address Postcode			Address Postcode	
Tel No.	Home		Tel No.	
	Work		Contact Tel No.*	
	Mobile		* Direct line of person booking i.e. GP secretary / receptionist	
Hospital No.				
NHS No.				

Is patient instructed to self-book? Yes ☐ No ☐

Preferred Contact No. ☐ Contact Time ☐

Is Language Line needed? Yes ☐ No ☐ Language Required ☐

PATIENT HAS BEEN INFORMED OF THE POTENTIAL DIAGNOSIS Yes ☐

Has this patient been seen by a Neurologist before? Yes ☐ No ☐

I have examined the patient prior to referral Yes ☐

Name of Consultant ____________________

Date Seen _____ / _____ / _____

Hull and East Yorkshire Hospitals NHS Trust

Patient's Name ______________________

Hospital Number ______________________

History

Category	Item	Yes	No
Rapidly Progressive Focal Deficit	Weakness / heaviness / clumsiness	Yes ☐	No ☐
	Unsteadiness	Yes ☐	No ☐
	Numbness / tingling	Yes ☐	No ☐
	Deafness in one ear	Yes ☐	No ☐
	Visual disturbance	Yes ☐	No ☐
Seizures	Focal Onset	Yes ☐	No ☐
	Post-ictal deficit	Yes ☐	No ☐
	Associated (inter-ictal) focal deficit	Yes ☐	No ☐
	De novo status epilepticus	Yes ☐	No ☐
Raised Intracranial Pressure	Headache	Yes ☐	No ☐
	Nausea / vomiting	Yes ☐	No ☐
	Double vision	Yes ☐	No ☐
	Intermittent drowsiness	Yes ☐	No ☐
Mental State Changes	Short history cognitive decline (e.g. memory loss)	Yes ☐	No ☐
	Short history behaviour / personality change	Yes ☐	No ☐

Examination Findings

Category	Item	Yes	No
Higher Mental Functions	Alert	Yes ☐	No ☐
	Orientated	Yes ☐	No ☐
	Attentive	Yes ☐	No ☐
	Forgetful	Yes ☐	No ☐
	Dysphasic	Yes ☐	No ☐
Cranial Nerves	Papilloedema	Yes ☐	No ☐
	Extracular Muscle Palsy	Yes ☐	No ☐
	Visual Field Loss	Yes ☐	No ☐
	Facial Weakness	Yes ☐	No ☐
	Unilateral Deafness	Yes ☐	No ☐
Limbs	Ataxia	Yes ☐	No ☐
	Hemiparesis	Yes ☐	No ☐
	Hemisensory Loss	Yes ☐	No ☐

Medical History / Drugs / Allergies / Other Comments

(Add additional sheets if required)

Date of Referral ______ / ______ / ______