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| --- | --- | --- |
| **Reference/Priority** | | |
| Referral Date: | Priority: | NHS Number: |
|  |  |  |

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| --- | --- | --- |
| **Patient Details** | | |
| Title: | Forename(s): | Surname: |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Contact Details** | | |
| Address Line 1: | Address Line 2: | Address Line 3: |
|  |  |  |
| Town: | County: | Postcode: |
|  |  |  |
| Home Phone: | Mobile: | Test Message Consent: |
|  |  |  |
| Email: |  |  |
|  |  |  |

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| --- | --- | --- |
| **Referrer/Practice Details** | | |
| Referring GP: | Referrer Code: | Practice Code: |
|  |  |  |

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| --- | --- | --- |
| **Clinic Details** | | |
| Specialty: | Clinic Type: | Named Clinician: |
|  |  |  |

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| --- | --- |
| **Patient Choice Preferences** | |
| Provider 1: | Provider 2: |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Preferences** | | |
| Vulnerable Patient: | Vulnerable Reason: | Confidential/Silent Referral: |
|  |  |  |
| Preferred Contact Time: | Interpreter Required: | Preferred Language: |
|  |  |  |

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| --- |
| **Referral Details** |
| Non-clinical Information for the Booking Team: |
|  |
| Provisional Diagnosis: |
|  |
| Smoking Status: |
|  |

NB Please note that up to date patient contact details and a telephone number where the patient can be reached during office hours (0830 – 1800) are essential to allow us to offer your patient a date within seven days of your referral

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| **Important:** |
| Is the patient available to attend an appointment within the next 14 days? Yes  No |
|  |
| Is the patient aware of the possible diagnosis of cancer? Yes  No |
|  |
| 2 week wait patient information leaflet given? Yes  No |
|  |
| Patient’s Performance Status: 0  Normal activity/well  1  Normal activity but symptomatic  2  Resting <50% of the day  3  Resting >50% of the day  4  Bed bound / inability to self-care |
|  |
| Any Additional Comments: |
|  |

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| **Referral Information:** |
| **Use CCG, Cancer MDT & LMC agreed**  [“Suspected MaxilloFacial Cancer”](https://northyorkshireccg.nhs.uk/wp-content/uploads/2021/08/suspected-maxfac-cancer-flowchart-1.pdf)  **Flowchart for referral criteria** |
|  |

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| **Condition Details** (tick appropriate boxes)**:** |
| **Unexplained ulceration in oral cavity or vermillion of lip for >3 weeks**  **Unexplained swelling/ lump in oral cavity or vermillion of lip**  **Red or red and white patches of oral mucosa**  **Unexplained and persistent lump / mass in neck (not thyroid)**  ***Risk Factors (tick appropriate boxes*)**  **Smoking**    **Tobacco Use**  **Heavy Alcohol Intake** |
| |  | | --- | | **Referral Text:** | |  | |
|  |
|  |