

# Suspected Cancer Referral for Brain and CNS



Suspected Cancer Referral for all patients over the age of 16 years

## Priority

Referral Date: Short date letter merged	Priority: Suspected Cancer Referral	NHS Number: NHS Number
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## Patient Details / Contact Information

Title: Title	Forename: Given Name	Surname: Surname	
Date of Birth: Date of Birth	Gender: Gender(full)	Ethnicity: Ethnic Origin	
Address: Home Full Address (stacked)	Home Telephone Number: Patient Home Telephone	Email: Patient E-mail Address	
Carer Status:	OR Mobile Telephone Number: Patient Mobile Telephone	Text Message Consent: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Preferred Contact Time:	Interpreter Required: Yes <input type="checkbox"/> No <input type="checkbox"/>	Preferred Language (written):	Preferred Language (spoken):

## Referrer / Practice Details

Referring Name: Current User	Referrer Code:	Practice Code: Registered GP Organisation National Practice Code
Registered GP: Registered GP Full Name	Surgery Name: Registered GP Organisation Name	Surgery Address: Registered GP Full Address (stacked)
Surgery Telephone Number: Organisation Telephone Number	Generic Surgery Email Address: Organisation E-mail Address	

## Mandatory Information – will be returned if not complete

**Most patients will have investigations prior to having an appointment or during their first hospital visit. It is therefore important that patients are prepared for this and aware of the reason for their referral. Please ensure the mandatory information below is provided and all relevant investigations are completed and attached.**

		Yes	No
1.	Has the patient been informed they are on a suspected cancer pathway, given appropriate support and advised they need to be available <b>at any time</b> within the next two weeks? If no, please explain why: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can the patient be contacted by telephone? If yes, have you ensured that the telephone contact details are correct? Landline Number: <input type="text"/> OR Mobile Number: <input type="text"/>  If NO, why and what is the preferred method of contact? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can the patient be contacted by letter? Please expand below, if needed e.g. "Yes, but in preferred language", "Yes, but letter to be sent to	<input type="checkbox"/>	<input type="checkbox"/>

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	GP Practice", etc. <input type="text"/>		
4.	Have you told your patient they may have appointments and tests arranged at any hospital across Greater Manchester?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Accurate functional status is needed to assess the most appropriate investigation and treatment. Please select a score from one of the following and enter in the score field:	Score: <input type="text"/>	
	Rockwood Score 1-3    Managing Well. Not limited by any comorbidities		
	Rockwood Score 4    Vulnerable, not dependant, symptoms limit activities		
	Rockwood Score 5    Mildly frail, evident slowing, need help with daily activities		
	Rockwood Score 6    Moderately frail, need help with all outside activities and bathing		
	Rockwood Score 7-8    Severely frail, completely dependent for personal care		
	Rockwood Score 9    Terminally ill, life expectancy of <6 months		
6.	Are there any concerns about this patient's capability to consent to investigation/treatment? If Yes, has the next of kin/advocate been asked to attend?	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
7.	Is the patient taking anti-coagulants? If Yes please give details: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Is the patient diabetic and taking Metformin? If Yes please give details: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Current eGFR of patient:  <b>Recent changes to guidance mean eGFR is <u>no longer required in all patients</u>.</b>  <b>If the value is not appearing this has not been recorded in the last 3 months, therefore has the eGFR been requested today in patients:</b> <ul style="list-style-type: none"> <li>- with known renal disease (CKD 3/4/5 or renal transplant)</li> <li>- who are diabetic</li> <li>- who are on metformin</li> </ul>	Value: Single Code Entry: GFR (glomerular filtration rate) calculated by abbreviated Modification of Diet in Renal Disease Study Group calculation...	
		<b>Yes</b>	<b>No</b>
		<input type="checkbox"/>	<input type="checkbox"/>
10.	Does the patient require Translation or Interpretation Services? If Yes, which language: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Does the patient have any other health conditions, impairments or access requirements that may require support? (e.g. physical/learning disability): <input type="text"/>		

## Referral Reason *(include relevant family history and previous history of cancer)*

### Refer the following patients on appropriate local pathway

- Sudden onset neurological deficit (stroke / TIA)
- New onset seizure

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## BRAIN & CNS SUSPECTED CANCER REFERRAL:

	YES	NO
▪ Progressive / worsening neurological symptoms over 4-8 weeks	<input type="checkbox"/>	<input type="checkbox"/>
▪ Development of new sequential neurological symptoms over 4-8 weeks	<input type="checkbox"/>	<input type="checkbox"/>
▪ MRI or CT scan suggestive of brain tumour	<input type="checkbox"/>	<input type="checkbox"/>

## NEUROLOGICAL SYMPTOMS CAN INCLUDE:

	YES	NO
▪ Left sided weakness	<input type="checkbox"/>	<input type="checkbox"/>
▪ Right sided weakness	<input type="checkbox"/>	<input type="checkbox"/>
▪ Numbness	<input type="checkbox"/>	<input type="checkbox"/>
▪ Decreased verbal fluency	<input type="checkbox"/>	<input type="checkbox"/>
▪ Visual disturbance	<input type="checkbox"/>	<input type="checkbox"/>
▪ Personality change	<input type="checkbox"/>	<input type="checkbox"/>
▪ Change in cognitive function	<input type="checkbox"/>	<input type="checkbox"/>
▪ Headache	<input type="checkbox"/>	<input type="checkbox"/>

**Headache alone is unlikely to indicate a tumour but combined with other progressive neurological symptoms it may be significant**

## Please indicate if the patient has any of the following as may be a contraindication to MR Scanning:

	YES	NO
▪ Pacemaker / implanted defibrillator / implanted electrical device (e.g. TENS)	<input type="checkbox"/>	<input type="checkbox"/>
▪ Surgery in the last 6 weeks	<input type="checkbox"/>	<input type="checkbox"/>
▪ Coronary stents / valve replacement / brain aneurysm clips / breast tissue expanders	<input type="checkbox"/>	<input type="checkbox"/>
▪ Possible metal fragments in the eye (e.g. lathe worker) or elsewhere in the body (e.g. shrapnel)	<input type="checkbox"/>	<input type="checkbox"/>
▪ Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>

**Patients who cannot have an MRI scan may need a CT scan. Please attach MRI or CT report if available.**

## Consultations

Consultations

## Pathology

<b>Sodium</b>	Single Code Entry: Serum sodium level	<b>Total Chol.</b>	Single Code Entry: Serum total cholesterol level	<b>WCC</b>	Single Code Entry: Total white cell count...
<b>Potassium</b>	Single Code Entry: Serum potassium level	<b>LDL Chol.</b>	Single Code Entry: Serum low density lipoprotein cholesterol level	<b>Plat</b>	Single Code Entry: Platelet count...
<b>Urea</b>	Single Code Entry: Serum urea level	<b>HDL Chol.</b>	Single Code Entry: Serum high density lipoprotein cholesterol level	<b>MCV</b>	Single Code Entry: MCV - Mean corpuscular volume...
<b>Creatinine</b>	Single Code Entry: Serum creatinine level...	<b>Folate</b>	Single Code Entry: Serum folate level	<b>Ferritin</b>	Single Code Entry: Serum ferritin level
<b>eGFR</b>	Single Code Entry: Glomerular filtration rate...	<b>Bilirubin</b>	Single Code Entry: Serum bilirubin level		

## Haematology

**Haemoglobin:** Haemoglobin  
**Haemoglobin estimation:** Single Code Entry: Haemoglobin estimation  
**ALT:** ALT  
**Blood Glucose:** Blood Glucose  
**Alkaline Phosphatase:** Alkaline Phosphatase

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## Radiology

Radiology: Radiology

## Diabetic Control

HbA1c: HbA1c

## Thyroid Function

T4 / TSH Test (to ensure this is not repeated unnecessarily in secondary care)

**T4:** Single Code Entry: Serum free T4 level

**TSH:** Single Code Entry: Serum TSH (thyroid stimulating hormone) level

## Health Profile

Problems

Medication

Allergies

Family History

Alcohol Consumption

Smoking

Weight

Height

BMI

Blood Pressure

## Long Term Conditions

**IHD:** Single Code Entry: Aortocoronary artery bypass graft repeated...

**Diabetes:** Single Code Entry: Diabetes mellitus without complication...  
Single Code Entry: Diabetes mellitus type 1 with ketoacidotic coma...

**Hypertension:** Single Code Entry: Hypertensive disease...

**Epilepsy:** Single Code Entry: Recurrent complex partial epilepsy...

**Stroke/TIA:** Single Code Entry: Anterior cerebral artery syndrome...

**Parkinson's:** Single Code Entry: Parkinson's disease...

**Dementia:** Single Code Entry: Circumscribed cerebral atrophy...

**COPD:** Single Code Entry: Acute vesicular emphysema...

**CKD:** Single Code Entry: Chronic kidney disease stage 4...

**Neoplasms:** Single Code Entry: [X]Additional neoplasm classification terms...  
Single Code Entry: Neuroblastoma of central nervous system...

## Contraception

FOR FEMALE PATIENTS ONLY

(please check medication screen for items that may not have filtered through)

Single Code Entry: Prescribed postcoital oral contraceptive pill...