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| **URGENT SUSPECTED CANCER REFERRAL FORM****SUSPECTED CHILDREN’S CANCERS**  |
| **Please refer to CMCA Urgent Suspected Cancer Pathways for Children and Young People(link)**As per NICE guidance referrals may be: **Immediate, Very Urgent (48 hours)\* or Urgent (2 weeks)\***If there is a high suspicion of cancer (Immediate/Very urgent referral) please contact the consultant oncologist on call at Alder Hey Children’s Hospital via switchboard. 0151 228 4811All other referrals should be made into local services using the CMCA Urgent Suspected Cancer Form - Suspected Children’s Cancers *via e-RS (2WW Children and Young People)*For guidance on urgency of referral, consider telephone conversation with local paediatric consultant or on call oncologist, AHCH. Written guidance can be found: * [NICE NG12 Referral guidance for suspected childhood cancers](https://www.nice.org.uk/guidance/ng12/chapter/Recommendations-organised-by-site-of-cancer#childhood-cancers)
* [cclg-referral-guidance-april-2021.pdf](https://www.cclg.org.uk/sites/default/files/2025-02/cclg-referral-guidance-april-2021.pdf)
* Urgent Suspected Cancer Pathways for Children and Young People, CMCA, 2025
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| **PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD** |
| Has the patient, parent or guardian been counselled they are being referred to a suspected cancer service and the reason for referral? [NICE ng12 guidance/ patient support](https://www.nice.org.uk/guidance/ng12/chapter/Recommendations-on-patient-support-safety-netting-and-the-diagnostic-process#patient-information-and-support) | Yes  No   |
| Has the patient, parent or guardian been given relevant written information about this referral? | Yes  No   |
| Is the patient available within the next 48 hrs /14 days? \*If selected no, please explain why?  | Yes  No   |
| Have you checked all contact details are correct and informed that the initial appointment may be by telephone? | Yes  No   |
| **REFERRER DETAILS** |
| Referring GP | Free Text Prompt  | GP Code | Usual GP Organisation National Practice Code  |
| Usual GP | Usual GP Title Usual GP Forenames Usual GP Surname  |
| GP Address  | Usual GP Full Address (single line)  |
| GP Tel. No.  | Usual GP Phone Number  |
| GP secure email | Organisation E-mail Address  |
| Date seen by GP | Long date letter merged  | Decision to refer date | Long date letter merged  |
| **PATIENT DETAILS** |
| Title & Surname | Title Surname  | Forename(s) | Given Name  |
| Date of Birth | Date of Birth  | Age | Age  | Gender | Gender(full)  |
| NHS Number |  |  |  |  |  |
| Address | Home Full Address (single line)  |
| Home Tel No. | Patient Home Telephone  | Work Tel No. | Patient Work Telephone |
| Mobile Tel No. | Patient Mobile Telephone | Patient email | Patient E-mail Address  |
| Parent / Guardian  | NameContact Telephone Relationship  | Single Code Entry: Patient's next of kinFree Text PromptFree Text Prompt |
| **REFERRAL INFORMATION** |
| **Main reason for referral (**please explain why you think this child may have cancer )Free Text Prompt  |
| **Please refer to Urgent Suspected Cancer Pathways for Children and Young People link** |
| Please Indicate with X type of Cancer suspected | Please add additional information of symptoms and/or signs |
| **Abdominal Tumour**Palpable abdominal mass or abdominal distension - **Very urgent** |    |  |
| **Leukaemia-** Pallor, fatigue, bruising, petechiae, hepatosplenomegaly - **Immediate** |  |  |
| **Lymphoma**Enlarged lymph nodes fitting the criteria for referral - **Urgent** |  |  |
| **Bone Tumour**Chronic pain, palpable mass - **Urgent** |  |  |
| **Soft Tissue Sarcoma**Soft tissue mass lesion - **Urgent** |  |  |
| **Retinoblastoma** Absent red reflex - **Urgent**   |  |  |
| **Brain or spinal tumour**Symptoms of raised intracranial pressure, new squint - **Immediate** |  |  |
| **Skin Cancer**Meeting criteria for urgent suspected cancer referral - **Urgent** |  |  |
| **Breast**Meeting criteria for urgent suspected cancer referral - **Urgent** |  |  |
| **Thyroid**Meeting criteria for urgent suspected cancer referral -**Urgent** |  |  |
| **Not sure / Other** (please state)   |  |  |
| **ADDITIONAL INFORMATION :** |
| **Other Symptoms** | **Detail of symptoms/Length of time** |
|  |  |
| **Other Exam findings**  |  |
| **Any Additional Information** |  |
| **INVESTIGATIONS Bloods CXR**Please attach if no merged information is pulled through |
| Investigations  |
| **CULTURAL, MOBILITY STATUS AND ASSISTANCE REQUIREMENTS** |
| Does the patient have any Communication, Mobility or Safeguarding needs  | Yes  No   |
| **Please detail if there are any reasonable adjustments needed or additional requirements** | Free Text Prompt  |
| If the patient requires Translation or Interpretation Services **Please give details**: |  |
| What is the patient’s preferred first language? | Main Language  |
| Ethnicity | Ethnic Origin  |
| Religion (if recorded) | Religion  |
| Temporary resident | Yes  No   |
| Overseas visitor  | Yes  No   |
| **CLINICAL INFORMATION/HISTORY** |
| Consultations |
| Problems  |
| Values and Investigations  |
| Medication  |
| Allergies  |