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| Suspected paediatric 2 week wait referral |

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| Date of decision to refer: |  | Date referral received at Trust:  |  |

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| Patient Details | Surname: First Name: Title:  |
| Gender: DOB: / / NHS Number:  |
| Ethnicity: Language: |
| Interpreter required: Transport required: |
| Patient Address:  Postcode:  |
| Contact numbers:Home: Mobile: Email:  |
| Practice Details | Registered GP Name:  |
| Practice Name :  |
| Direct line to the practice (Bypass) : |
| Main: Fax: Email: |
| Referring Clinician:  |

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| If you are concerned about a suspected cancer in a child, all trusts across Wessex recommend that you to talk directly to the paediatric consultant of the day. This form is for information and to ensure referral details are transferred. *This is for children <16y, for young adults (16 and over) please use the adult form.* |
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| **Specific referral information:** |
| Leukaemia | Blood film report suggests leukaemiaUnexplained petechiae or hepatosplenomegaly | Same day |
| Hodgkin’s and Non-Hodgkin’s Lymphoma | Unexplained lymphadenopathy or splenomegaly(consider associated symptoms e.g. fever, night sweats, pruritus, weight loss or shortness of breath) | To be seen within 48hrs |
| Brain and CNS cancers | New onset cerebellar or neurological signs |
| Neuroblastoma | Palpable abdominal mass or unexplained enlarged abdominal organ |
| Wilm’s tumour | Palpable abdominal mass or unexplained enlarged abdominal organUnexplained visible haematuria |
| Sarcoma | X-ray suggests possible bone sarcomaUSS suggests soft tissue sarcoma orUSS is uncertain and clinical suspicion persists |
| Retinoblastoma | Absent red reflex |

**Please tick YES if any of the following apply to your patient:**

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| ☐ | Patient has cognitive impairment that may affect their mental capacity for consent.  |
| ☐ | Patient is Looked-AfterIf yes, please confirm date best interests meeting completed: \_\_/\_\_/\_\_\_\_ |
| ☐ | Patient has significant sensory impairment (specify): |
| ☐ | Patient will require an interpreter (specify): |

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| Clinical Information  | **Details of other significant medical history:** |
| **List or attach regular medication:** |