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| Suspected brain cancer 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: |

**SPECIFIC 2 WEEK WAIT REFERRAL INFORMATION:**

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| ☐ Progressive, sub-acute loss of CNS function - *Urgent referral for imaging, ideally MRI, or CT scan if MRI is contraindicated (if available locally) otherwise refer directly to neurology.*  ☐ <25y with new abnormal CNS or cerebellar function; **Arrange review within 48h** | |
| **Please describe reasons for suspected brain tumour:**   |  | | --- | |  |   **Blood results (ESSENTIAL)**   |  | | --- | | Please ensure the following recent blood results are available (U&Es must be within 4 weeks):  **Na \_\_\_\_\_ K \_\_\_\_ eGFR \_\_\_\_** *(tumour markers are only indicated for disease monitoring)* | | |
| ☐ | **The patient is aware that this is a fast track referral to exclude brain cancer** |
| ☐ | The patient has been provided with a cancer pathway leaflet |
| ☐ | The patient is aware and able to attend an outpatient appointment within the next two weeks |

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

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| ☐ | Patient not suitable for MRI imaging (patient choice or contraindication) |
| ☐ | Patient has cognitive impairment that may affect their mental capacity for consent.  If yes, please confirm date best interests meeting completed: \_\_/\_\_/\_\_\_\_ |
| ☐ | Patient has significant mobility impairment |
| ☐ | Patient has significant sensory impairment (specify): |
| ☐ | Patient will require an interpreter (specify): |

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| Clinical Information | **WHO Performance Status (please circle)** | |
| **0**  **1**  **2**  **3**  **4** | Fully active  Restricted in physically strenuous activity but ambulatory and able to carry out light work  Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours  Capable of only limited self-care, confined to bed/chair 50% of waking hours  No self-care, confined to bed/chair 100% |
| **Details of other significant medical history:** | |
| **Anticoagulation and / or antiplatelet** **medication** – please state indication, medication taken and latest INR if applicable:  **List or attach regular medication:** | |