|  |
| --- |
| Suspected thyroid cancer 2 week wait referral |

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

|  |  |
| --- | --- |
| 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**

|  |
| --- |
| **Thyroid** swelling with:☐ Solitary nodule, typically hard increasing in size☐ Unexplained hoarseness or voice change associated with goiter☐ Symptoms of tracheal compression☐ Enlarged cervical nodules☐ family history of endocrine tumour☐ History of neck irradiation☐ Pre-pubertal patients☐ aged >65y |

|  |  |  |
| --- | --- | --- |
| **Additional clinical information**

|  |
| --- |
|  |

**Blood results (ESSENTIAL)**

|  |
| --- |
| Please ensure the following recent blood results are availableTFTs |

 |
| ☐ | **The patient is aware that this is a 2 week wait referral to exclude thyroid cancer** |
| ☐ | The patient has been provided with a cancer pathway leaflet |
| ☐ | Patient available and able to attend an outpatient appointment within the next two weeks |

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

|  |  |
| --- | --- |
| ☐ | 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): |

|  |  |
| --- | --- |
| 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:** |