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| Suspected skin 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: |

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| **SPECIFIC 2 WEEK WAIT REFERRAL INFORMATION**   |  |  |  | | --- | --- | --- | | **Melanoma** | **Squamous Cell Carcinoma** | **High Risk Basal Cell Carcinoma** | | Suspicious lesion scoring ≥ 3 on the weighted list (please mark)  **MAJOR** (scoring 2 points each)  ☐Change in colour  ☐Irregular shape  ☐Irregular colour  **MINOR** (scoring 1 point each)  ☐Largest diameter ≥7mm  ☐Inflammation  ☐Oozing  ☐Change in sensation  **SCORE: \_\_\_\_\_\_**  ☐ Pigmented or non-pigmented lesion suggestive of nodular melanoma  ☐ Dermoscopy findings suggestive of malignant melanoma  (Please describe findings below) | ☐ Lesion is suspicious of a squamous cell carcinoma. | ☐Concerning site or size (i.e. periocular involvement)  (Please specify special concern below)  **ONLY** consider a 2ww referral if the skin lesion is suspicious of a BCC **and** delay in treatment may cause harm because of lesion site or size. In **all** other cases refer to routine dermatology service. | | **Clinical description of the lesion (MANDATORY)**  **Site ……………….**  **Size (mm) ………………** | | | | **Anticoagulation and / or antiplatelet medication – please state indication, medication taken and latest INR if applicable:** | | | | **Pacemaker/ICD:** ☐ **Yes** ☐ **No** | | | | **List or attach regular medication:** | | | | |
|  | **Please tick YES if any of the following apply to your patient:** |
| ☐ | **The patient is aware that this is a 2 week wait referral to exclude skin 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 |
| ☐ | 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): |
| ☐ | Patient has a pace-maker (which may affect use of diathermy) |

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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:** | |