|  |
| --- |
| Suspected skin 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**

|  |  |  |
| --- | --- | --- |
| **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) |

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