Date of referral **Short date letter merged**

Name :	**Full Name**	DOB :	**Date of Birth**	NHS No	**NHS Number**

Attach this form to the e-referral

If the ERS not available, then send this form AND 'Referral header sheet' by secure email

Patient has been informed that this is a referral for suspected Basal Cell Carcinoma

Hyperlinks to: **NICE GUIDANCE** **BAD GUIDANCE**

ROUTINE referral unless there is specific concern that delay would have a significant impact – because the size or site of the lesion i.e., rapidly growing lesion near to eye/ or auditory canal. In that case, refer as 2WW

IF THERE IS ANY POSSIBILTY OF AN SCC THEN PLEASE DO AN URGENT 2WW SKIN Referral (RAPID GROWTH, LARGE SIZE, PAIN) and use the 2WW SKIN FORM

Tele-dermatology

Newcastle, Gateshead, Northumberland and North Tyneside, South Tyneside, Sunderland, County Durham and Darlington: 3 photos are required for suspected basal cell skin cancer e-referrals whenever possible. Photos will allow for rapid diagnostic triage to an appropriate clinical pathway. If photos are not appropriate (do not include photos of genital lesions) or technology fails, please indicate below.

GP photos with a dermatoscopic image provide the safest triage of this referral, patient submitted photos of good quality can be used where GP photography is not available.

3 x Photos required: 30 cm 10 cm Dermatoscopic image

Patient consent to tele-dermatology Service

The images will be assessed within 2 to 4 weeks. Following this an appropriate appointment will be made.

Hyperlinks to: Tele dermatology Technology Demo video Digital Tele dermatology Resources on GP Teamnet

Is your patient able to manage a telephone contact?	Yes No

SITE of lesion: Free Text Prompt **Right side Left side**	**SIZE of lesion in mm: Free Text Prompt**
Reason for Referral – Please complete all sections	
History of this lesion, time scale and changes observed	
Any previous skin malignancy/premalignancy and treatments given?	

: Excision of malignant skin tumour...

Any immunosuppression? YES NO **Details of immunosuppression:**
Unable to send images: YES The patient may be sent an invitation to use an app and send their own photos. Failing that, they will have to wait for the next available FTF NEW appointment,
Any additional information relevant to the referral? (sun/sunbed exposure, previous treatment, or biopsies)

Consent		
	No problems with consent anticipated	
	There may be problems with consent. – e.g., significant dementia or learning disability	**Include details in referral narrative** of adjustments required or best interest decision
Disability		
	No difficulty coping with investigation anticipated. No cognitive impairment/physical or behavioural issues that would make it difficult to manage the investigation	
	There may be difficulties coping with investigation due to physical or mental disability	**Include details in referral narrative** including known adjustments.

Please indicate COVID 19 risk:		
	Standard	No co-morbidities
	Vulnerable	Co-morbidities/frailty
	Shielded	In the shielded group because of high risk from COVID 19 infection

Description	Yes	No	
Anticoagulants including DOACS			
Antiplatelet e.g., Clopidogrel, Prasugrel			
Pacemaker or implanted Defibrillator			Single Code Entry: Cardiac pacemaker in situ Single Code Entry: Cardiac defibrillator in situ

Referrer details

Name of referrer:	**Referring User**	Date of referral:	**Short date letter merged**
Referring Organisation **Organisation Name , Organisation Full Address (single line)** Tel: **Organisation Telephone Number** Email: **Organisation E-mail Address** Fax: **Organisation Fax Number**		**GP details** **Usual GP Full Name** **Usual GP Organisation Name Usual GP Full Address (single line)** Tel: **Usual GP Phone Number** Fax: **Usual GP Fax Number**	
Name of GP to address correspondence to, if different to accountable GP			

Patient details

Name:	**Full Name**		**Addres**	**Home Full Address (stacked)**	
Gender:	**Gender(full)**		**s:**		
DOB & Age:	**Date of Birth** Age**: Age**				
NHS number:	**NHS Number**				
Patient Contacts:	Home:	**Patient Home Telephone**	Mobile:	**Patient Mobile Telephone**	
	Work:	**Patient Work Telephone**	Email:	**Patient E-mail Address**	
	Carer/Advocate: The patient has confirmed the following person should be included in correspondence – Name: Contact Details:				
Contact Consent:	Can leave message on answer machine Can contact by text Can contact by Email		NB: Not all services use Texts or Emails as a method of communication.		
Ethnicity:	**Ethnic Origin**				
Interpreter:	**Yes** Language: **Single Code Entry: Main spoken language English...**				
Accessibility Needs:	Wheelchair access Deaf **Single Code Entry: Partial deafness...** Registered Blind **Single Code Entry: Registered blind** Learning Disability, **Single Code Entry: On learning disability register Single Code Entry: Moderate learning disability...** Other disability needing consideration Accompanied by Carer				
Risks:	Vulnerable Adult (Details of any recording within last 3 years) **Single Code Entry: Vulnerable adult Single Code Entry: No longer a vulnerable adult...** **Single Code Entry: Difficult intubation** Other:				
Other adjustments required to support access to this service					

Accessible information

Communication support: Uses a legal advocate...
Contact method: Requires contact by telephone...
Information format: Requires information verbally...
Professional required: Interpreter needed - British Sign Language...