Suspected Cancer in Adults

Head and Neck (2ww)

Referrals from Dentists

NHS Northern Cancer Alliance

Date of Referral:

Name		DOB		NHS No	

Hyperlink: Send this form by Secure Email

Patient has been informed that this is an urgent referral for suspected cancer
The patient is available and willing to attend hospital for tests/appointment within 14 days
The patient has been given the 2WW patient information leaflet

Hyperlinks to: **NICE GUIDANCE** **2WW Patient Information Leaflet**

NICE Guidance		
	SITE of LESION:	
	ENT	
☐	Patients over 45 with persistent (not intermittent or fluctuating), unexplained hoarseness	
☐	Persistent, unexplained lump in the neck or parotid region of recent onset. (It is advisable to wait 3 weeks after an upper respiratory tract infection for reactive lymph nodes to improve)	
☐	Unexplained, persistent, unilateral enlargement or ulceration of the tonsil or adjacent soft palate	
	ORAL & MAXILLOFACIAL	
☐	Unexplained ulceration or lump on the lips or in the oral cavity lasting more than 3 weeks	
☐	Persistent, unexplained lump in the neck or parotid region of recent onset	
☐	New unexplained red or red and white patch in oral cavity consistent with Erythroplakia /erythroleukoplakia; lasting more than 3 weeks and having been present less than six months.	
	NOT TO BE USED FOR THE FOLLOWING: **Toothache or Dental Infection** **or** **Delayed and Unexplained Non-Healing of a Dental Socket of less than 3 weeks**	

Reason for Referral – Compulsory*

Social context

Alcohol consumption

Smoking history

Name		DOB		NHS No	

Significant Past Medical History

Prescribed Medication

Any known Allergies

Non-therapeutic drug use

Any known risk to others

Please complete the rest of this form

Name		DOB		NHS No	

Referrer details

Name of Referrer:		Dentist Surgery Address:
Dentist surgery Telephone number:		
Dentist surgery e-mail address		

GP Details

Usual GP:		GP Address:
GP surgery Telephone number:		
GP surgery email address		

Patient details

Name:		Address:
Gender:		
DOB & Age		
NHS Number:		
Home Tel No		**Contact Consent** (NB: not all services use texts or emails as method of communication) please select:
Mobile No:		☐ Can leave a message on answer machine
Email address:		☐ Can contacted by text
Work Tel No		☐ Can contacted by email
Carer/Advocate:	**The patient has confirmed the following person should be included in correspondence**: Name: Contact details:	
Ethnicity:		
Interpreter:	**Yes** ☐ Language:	
Accessibility Needs:	☐ Wheelchair access ☐ Deaf ☐ Registered Blind ☐ Learning Disability ☐ Other disability needing consideration ☐ Accompanied by Carer	
Risks:	☐ Vulnerable Adult Any other known risk:	
Other	☐ Military Veteran	

To be completed by the Data Team (Insert Dates)
Received: / / First Appointment booked: / / **First Appointment date: / / 1st seen: / /** **Specify reason if not seen on 1st appointment:** **Diagnosis: Malignant ☐ Benign ☐**