

**Suspected Cancer in Adults
BRAIN and CNS (2WW)**

Date of Referral: **Short date letter merged**

Name	Full Name	DOB	Date of Birth	NHS No	NHS Number
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Attach this form to the e-referral within 24 hours

If ERS is not an option, please send [this form](#) **AND** [‘Referral Header Sheet’ \(EMIS only\)](#) to the PROVIDER

Patients who are medically stable should be referred to CNS MDT below:

Newcastle: use eRS

South Tees Email: stees.twoweekrule@nhs.net

Those who are medically unstable should be admitted to their local hospital for initial treatment and referred to the appropriate CNS team as an inpatient.

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

Hyperlinks to: [NICE GUIDANCE](#) [Patient info leaflet including easy read](#)

This form is for Adults with Suspected Cancer, but not patients with metastatic spinal cord lesions

<input type="checkbox"/>	Abnormal MRI/CT suspicious of brain cancer (please enclose report and where investigation was performed)
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NICE GUIDANCE

Consider an urgent direct access MRI scan of brain (or CT scan with contrast if MRI is contraindicated) to be performed within 2 weeks

For Adults with progressive, sub-acute loss of central neurological function:

- Progressive neurological deficit (e.g. unilateral weakness, hemianopia).
- Progressive cognitive deficit or personality change (if atypical for dementia or mood disorder).
- Adults with new onset focal seizures (with or without secondary generalisation or, **Urgent** referral to **NEW ONSET epilepsy clinic**)

NOT for: isolated headache with normal examination

MRI

If MRI suggests a brain tumour and the patient is unwell admit as emergency to your local hospital.

If the patient is stable and MRI suggests a primary tumour or single metastatic lesion, refer to Neuro-oncology MDT using this form.

Multiple metastatic lesions on MRI

Patient stable + known primary - URGENT referral to specialist for primary disease/discuss with specialist

Patients stable + unknown primary URGENT discussion with neurosurgery + radiology to plan further investigations

Or, refer to malignancy of unknown origin pathway, if available.

If the MRI is normal the patient should be referred to either first seizure or neurology clinic.

Reason for Referral

(Please include the date of symptom onset and details of symptoms including neurological deficits and what the patient knows.) The clinical information is essential to safe and effective care of your patient.

Specific Past Medical History (including previous or existing malignancy, name of their oncologist, disease status and if oncologist has been contacted)

NB: The full Medical History, Medication and any known allergies can be found below

Treatments started and effects: (e.g. steroids, ppi & anti-coagulants, how long, include response)

Description	Y	N	Description	Y	N
Warfarin	<input type="checkbox"/>	<input type="checkbox"/>	NOAC e.g.	<input type="checkbox"/>	<input type="checkbox"/>
Antiplatelet e.g. Clopidogrel, Prasugrel	<input type="checkbox"/>	<input type="checkbox"/>	Rivaroxaban/Dabigatran/Apixaban/Edoxaban	<input type="checkbox"/>	<input type="checkbox"/>
Insulin/Sulfonylureas	<input type="checkbox"/>	<input type="checkbox"/>	Metformin	<input type="checkbox"/>	<input type="checkbox"/>

Performance Status	<input type="checkbox"/>	0	Fully active
	<input type="checkbox"/>	1	Cannot carry out heavy physical work
	<input type="checkbox"/>	2	Up and about more than half the day and can look after yourself
	<input type="checkbox"/>	3	In bed or sitting in a chair for more than half the day and need help in looking after yourself
	<input type="checkbox"/>	4	In bed or a chair all the time and need a lot of looking after

Please indicate COVID 19 risk:		
<input type="checkbox"/>	Standard	No co-morbidities
<input type="checkbox"/>	Vulnerable	Co-morbidities/frailty
<input type="checkbox"/>	Shielded	In the shielded group because of high risk from COVID 19 infection

Investigations/procedures: (key tests imported if recorded on clinical system)

If blood test result does not appear below but have been requested, please tick and date the appropriate box.

U&Es	<input type="checkbox"/> Requested	Date:	Result within last month		Latest Result	
Sodium			Single Code Entry: Serum sodium	Single Code Entry: Serum sodium	Single Code Entry: Serum sodium	Single Code Entry: Serum sodium
Potassium			Single Code Entry: Serum potassium	Single Code Entry: Serum potassium	Single Code Entry: Serum potassium	Single Code Entry: Serum potassium
Urea			Single Code Entry: Serum urea level	Single Code Entry: Serum urea level	Single Code Entry: Serum urea level	Single Code Entry: Serum urea level
Creatinine			Single Code Entry: Serum creatinine	Single Code Entry: Serum creatinine	Single Code Entry: Serum creatinine	Single Code Entry: Serum creatinine

eGFR result within last month Requested Date:

Single Code Entry: eGFR using creatinine (CKD-EPI) per 1.73 square metres...	Single Code Entry: eGFR	Single Code Entry: eGFR	Single Code Entry: eGFR using creatinine (CKD-EPI) per 1.73
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eGFR latest result

Single Code Entry: eGFR using creatinine (CKD-EPI) per 1.73 square metres...	Single Code Entry: eGFR	Single Code Entry: eGFR	Single Code Entry: eGFR using creatinine (CKD-EPI) per 1.73
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Title Given Name Surname

Date of Birth

NHS Number

Referrer details

Name of Referrer: <input type="text"/>	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:		<input type="text"/>

Patient details

Name:	Full Name	Address:	Home Full Address (stacked)	
Gender:	Gender(full)			
DOB and 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: <input type="text"/> Contact Details: <input type="text"/>			
Contact Consent:	<input type="checkbox"/> Can leave message on answer machine <input type="checkbox"/> Can contact by text <input type="checkbox"/> Can contact by Email		NB: Not all services use Texts or Emails as a method of communication.	
Ethnicity:	Ethnic Origin			
Interpreter:	<input type="checkbox"/> Yes Language: Single Code Entry: Main spoken language <input type="text"/>			
Accessibility Needs:	<input type="checkbox"/> Wheelchair access <input type="checkbox"/> Deaf Single Code Entry: Deafness <input type="checkbox"/> Registered Blind Single Code Entry: Registered blind <input type="checkbox"/> Learning Disability Single Code Entry: On learning disability register Single Code Entry: [X]Specific developmental disorders of scholastic skills <input type="checkbox"/> Other disability needing consideration <input type="text"/> <input type="checkbox"/> Accompanied by Carer			
Risks:	<input type="checkbox"/> Vulnerable Adult (details below if any recording in last 3 years) Single Code Entry: Vulnerable adult Single Code Entry: Adult no longer vulnerable Single Code Entry: Failed or difficult intubation Other: <input type="text"/>			
Other: Single Code Entry: Military veteran Single Code Entry: Left military service Single Code Entry: History relating to military service Single Code Entry: Occupation history Single Code Entry: Has a carer Single Code Entry: Is no longer a carer Single Code Entry: Is a carer Single Code Entry: Carer				

Accessible Information

Communication Support: Uses a legal advocate...

Professional Required: Interpreter needed - British Sign Language...

Contact Method: Requires contact by telephone...

Information format: Requires information verbally...

[If you have any problem with this form or suggested changes, please control & click here to open direct email.](#) **(NB: NOT TO BE USED FOR REFERRING A PATIENT)** 2WW NCA Brain/CNS Referral Form – EMIS Web V4 Gateshead April 2018

Title Given Name Surname

Date of Birth

NHS Number

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