Suspected Cancer in Adults
SKIN (Fast track)

Clinical Digital Resource Collaborative — Join our Journey
CDRC Supporting Clinical Decisions — North East and North Cumbria

NHS Northern Cancer Alliance

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 within 24 hours

If the ERS not available, then send this form AND 'Referral header sheet' 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 Fast track patient information leaflet

Hyperlinks to: NICE GUIDANCE Patient info leaflet including easy read

Suspected Malignant Melanoma ☐ Suspected Squamous Cell Carcinoma ☐

Melanoma diagnosed on primary care biopsy: please phone the local skin cancer nurse specialist to arrange an urgent appointment

Suspected basal cell carcinoma: 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 **PLEASE DO AN URGENT NON**-Fast track **referral.**

Hyperlink to: PCDS skin lesion diagnostic tool

Tele-dermatology

Newcastle, Gateshead, Northumberland and North Tyneside, South Tyneside, Sunderland, County Durham and Darlington: 3 photos are required for all skin lesion e-Referrals. If photos are not appropriate due to site (do not include photos of genital lesions) or if technology fails, please indicate in the free text history section below.

Photos required: Site ☐ 20cm ☐ Dermatoscopic image ☐

Patient consent to tele-dermatology service ☐

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

SITE of lesion: Free Text Prompt	**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:

Any family history of melanoma? YES ☐ NO ☐

: Family history of malignant melanoma

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

Anticoagulants	**Yes**	**No**	**Antiplatelets**	**Yes**	**No**
Anticoagulants including DOACS	☐	☐	Antiplatelet e.g., Clopidogrel, Prasugrel	☐	☐
Pacemaker/Defibrillator	**Yes**	**No**	**Mail merged information, if recorded**		
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**		**Address:**	**Home Full Address (stacked)**
Gender:	**Gender(full)**			
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 yrs) **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...

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) NCA Fast track SKIN Referral Form July 2021 EMIS Web v6 SNOMED CDRC

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 ☐