

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 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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	
<input type="text"/>	
Any previous skin malignancy/premalignancy and treatments given?	
<input type="text"/>	

: Excision of malignant skin tumour...

Consultation:
Consultations

Any immunosuppression? YES <input type="checkbox"/> NO <input type="checkbox"/>
Details of immunosuppression: <input type="text"/>
Any family history of melanoma? YES <input type="checkbox"/> NO <input type="checkbox"/>

: Family history of malignant melanoma

Any additional information relevant to the referral? (sun/sunbed exposure, previous treatment, or biopsies)

Consent		
<input type="checkbox"/>	No problems anticipated	
<input type="checkbox"/>	There may be problems with consent. – e.g., significant dementia or learning disability clinical assessment may be needed before investigations	Include details here: <input type="text"/>
Disability		
<input type="checkbox"/>	No difficulty coping with investigation anticipated. No cognitive impairment/physical or behavioural issues that would make it difficult to manage the investigation	Straight to test investigations will be considered (expected to be able to move around and complete investigations)
<input type="checkbox"/>	There may be difficulties coping with investigation due to physical or mental disability Clinic first may be offered.	Include details here including known adjustments. <input type="text"/>

Anticoagulants	Yes	No	Antiplatelets	Yes	No
Anticoagulants including DOACS	<input type="checkbox"/>	<input type="checkbox"/>	Antiplatelet e.g., Clopidogrel, Prasugrel	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Defibrillator	Yes	No	Mail merged information, if recorded		
Pacemaker or implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Single Code Entry: Cardiac pacemaker in situ Single Code Entry: Cardiac defibrillator in situ		

Referrer details

Name of referrer:	Referring User <input type="text"/>	Date of referral:	Short date letter merged
Referring Organisation		GP details	
Organisation Name , Organisation Full Address (single line) Tel: Organisation Telephone Number Email: Organisation E-mail Address Fax: Organisation Fax Number		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 & 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 English... <input type="text"/>		
Accessibility Needs:	<input type="checkbox"/> Wheelchair access <input type="checkbox"/> Deaf Single Code Entry: Partial 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: Moderate learning disability... Single Code Entry: Impairment with substantial and long term adverse effect on normal day to day activity (Equality Act 2010) Single Code Entry: Requires reasonable adjustment for health and care access (Equality Act 2010)... <input type="checkbox"/> Other disability needing consideration <input type="text"/> <input type="checkbox"/> Accompanied by Carer		
Risks:	<input type="checkbox"/> 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: <input type="text"/>		
Other adjustments required to support access to this service <input type="text"/>			

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 email contact-cdrc@healthinnovationenc.org.uk (NB: NOT TO BE USED FOR REFERRING A PATIENT) NCA SKIN Urgent Suspect Cancer December 2025 CDRC Snomed EMIS Web. **This form has been developed by CDRC (Clinical Digital Resource Collaborative) – CDRC partners include NENC ICB, HI NENC, CBC Health Federation Ltd, NECS, Cumbria PRIMIS Informatics, and Derwentside Health Ltd. All intellectual property rights belong to the NENC ICB, this form cannot be copied or distributed by any other organisation.**

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