

Please use separate children's proforma for patients under 16

Patient Details			
Patient Name			
Address			
DOB		NHS No.	
Home Tel. No.		Gender	
Mobile Tel. No.		Ethnicity	
Preferred Tel. No.		Email Address	
Main Spoken Language		Interpreter needed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Transport needed?		Patient agrees to telephone message being left?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communication requirements	Hard of hearing: <input type="checkbox"/> Visually impaired: <input type="checkbox"/> Learning/mental difficulties: <input type="checkbox"/> Dementia: <input type="checkbox"/> Communication difficulties other: (please specify) \${communicationDifficultiesOther}		
Consent obtained for Imaging (Photograph sent)	Photo included <input type="checkbox"/>		
Patient has device which accepts video calling?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date of Decision to Refer			

Registered GP Details			
Practice Name			
Registered GP		Usual GP / Referring GP	
Registered GP Address			
Tel No.		Fax No.	
Email		Practice Code	

Registered Dentist Details			
Patient registered with a dentist	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Practice Name			
Registered / Usual dentist		Referring dentist	
Practice address			
Tel No.		Email	

Patient Engagement	
The patient has been informed that the reason for referral is to rule out or rule in Cancer.	<input type="checkbox"/>
Supporting information (2ww leaflet) provided	<input type="checkbox"/>
The patient has been informed of the likely next pathway steps and the time in which they should be contacted?	<input type="checkbox"/>
The patient has confirmed that they are willing and available to be contacted and attend the hospital for appointments and tests within the required timeframes? (and that this may include virtual or telephone consultations if appropriate)	<input type="checkbox"/>
Does the patient want a relative present at the appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient or Carer Concerns/ Support Needs at the point of referral:	

### Covid status

I can confirm the patient has been fully vaccinated

Yes  No

	Emergency (Contact Consultant and admit)	Yes	2WW	Yes	Consider urgent referral for assessment by a General Dental Practitioner:	Yes
<b>Thyroid</b>			Thyroid mass associated with unexplained hoarseness or voice change, cervical lymphadenopathy or rapid enlargement over a period of week	<input type="checkbox"/>		
<b>Head and Neck Cancer</b>  <b>ENT</b>	Stridor	<input type="checkbox"/>	Lump or ulceration in tonsil/oropharynx  Persistent and unexplained neck lump  Persistent unexplained hoarseness >45 years	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>		
<b>Head and Neck Cancer</b>  <b>Maxillo-Facial Surgery</b>			Persistent and unexplained neck lump  A lump or lesion of oral cavity (lip/teeth/gums/palate/tongue/floor of mouth/mucosa, NOT Tonsil)  Unexplained ulceration in oral cavity lasting >21d	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>	<b>Unexplained:</b>  Lump on lip or oral cavity that has not been assessed by a dental surgeon  Red or white patch in the oral cavity consistent with erythroplakia or Erythroleukoplakia	<input type="checkbox"/>  <input type="checkbox"/>
<p style="color: red;"><b>If your patient does not meet NICE suspected cancer referral criteria, but you feel they warrant further investigation, please disclose full details in your referral letter.</b></p>						<input type="checkbox"/>

### Risk factors

**Thyroid**

- Over 55 yrs
- Previous neck irradiation
- Family history of endocrine tumours

	<input type="checkbox"/> Family history of thyroid tumours
<b>Head and neck</b>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Smoking

<b>Referral Letter</b> (please include any symptoms and examination findings)

Additional clinical information	
<b>Family history</b>	
<b>Smoking history</b>	
<b>Alcohol intake</b>	
<b>Latest BP</b>	
<b>Latest height</b>	
<b>Latest weight</b>	
<b>Latest BMI</b>	

Relevant investigations	
All patients requiring a 'suspicious of cancer' referral must have a recent (< 3 months) U&E result to facilitate efficient pathway next steps.	
<b>U&amp;E</b>	
<b>Other</b>	

Performance status - WHO classification	
<b>0 - Able to carry out all normal activity without restriction</b>	<input type="checkbox"/>
<b>1 - Restricted in physically strenuous activity, but able to walk and do light work</b>	<input type="checkbox"/>
<b>2 - Able to walk and capable of all self-care, but unable to carry out any work. Up and about more than 50% of waking hours</b>	<input type="checkbox"/>
<b>3 - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours</b>	<input type="checkbox"/>

4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair



## Consultations

## Past Medical History

## Family history

## Current Medications

## Allergies

To be completed by the Hospital Data Team	
Date of decision to refer	
Date of appointment	
Date of earliest offered appointment (if different to above)	
Specify reason if not seen at earliest offered appointment	
Periods of unavailability	
Booking number (UBRN)	

Final diagnosis: Malignant  Benign