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| **2 week Urgent Referral for Suspected Head & Neck Cancer (*ex*cluding Thyroid)** | |
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**Please follow this link** [**Ctrl Click occg.info/COVID-19-2WW-pathways**](http://occg.info/COVID-19-2WW-pathways) **before proceeding,   
to see current advice for this pathway**

**Do NOT use this form for Thyroid referrals -** use “2WW Suspected Thyroid Cancer”

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| **Patient’s details** | | | | | | **Patient’s background and culture** | | |
| Surname | |  | | | | Ethnicity |  | |
| Forename | |  | | | | 1st Language |  | |
| Known As | |  | | | | Interpreter required? Y  N | | |
| DOB | |  | | Age |  | **GP details** | | |
| Sex | |  | | Title |  |  | | |
| NHS No | |  | | | | Referring GP |  | |
| Address &  Postcode | |  | | | | GP Address |  | |
| Hospital No | |  | | | | GP Tel No |  | |
| Email | |  | | | | Practice Email |  | |
| **Phone Numbers** | | | Preferred Number(s) | | Can leave messages? | **Referral Dates** | | |
| Home |  | |  | |  | Referral date |  | |
| Work |  | |  | |  | Date received |  | |
| Mobile |  | |  | |  |  |  | |
| **Dentist details (if known)** | | | | | | | | |
| Name | |  | | | | Telephone Number | |  |
| Practice | |  | | | | Fax Number | |  |

| **2ww referral communication checklist**  **it is essential that you answer all questions in this section** | | |
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| I have explained to the patient that they may have cancer and I am  referring them on the 2 Week Wait Suspected Cancer Pathway | Yes | No – why not? |
| Is the patient available for an appointment within the next 14 days? | Yes | *NB. Please only submit this referral when the answer is* ***Yes*** |
| Has the patient been given the Fast Track Pathway information leaflet?  Information leaflets can be printed from here  Ctrl-Click **[occg.info/2WW-PIL](http://occg.info/2WW-PIL)** | Yes | No – why not? |
| IMPORTANT:  Please ensure this patient is available from referral for further hospital appointments and investigations.  Failure to check this may result in wasted appointments.  If the patient cannot attend immediately (e.g. booked travel) please negotiate a delay in referral.  Please indicate any exceptional circumstances here | | |
| I have explained to the patient that, to ensure they are seen within  14 days, appointments may be offered at either Oxford or Banbury | Yes | No – why not? |

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| **Referral Criteria**  Ctrl-Click [**occg.info/2ww-HeadandNeck**](http://occg.info/2ww-HeadandNeck) | | | | | | |
| **Thyroid** | Please use the dedicated form “2WW Suspected Thyroid Cancer” | | | | | |
| **ERS Service Selection**  **Specialty: 2WW Clinic Type: 2WW Head & Neck**  ***If ERS is unavailable*** please email to **PCC2wwOxford@nhs.net** and request a Read Receipt when sending | | | | | | |
| **ENT** | **Salivary Gland** | |  | Details: | **Please select all three hospital clinics for ENT referrals**  ✓ Suspected Head and Neck Cancer-ENT-(JR)  ✓ Suspected Head and Neck Cancer-ENT-(CH)  ✓ Suspected Head and Neck Cancer-ENT-(HGH)  ***Plus* select any appropriate local 2ww ENT clinics**  □ Suspected Head and Neck Cancer-2ww-ENT-(Wantage)  □ Suspected Head and Neck Cancer-2ww-ENT-(Witney)  □ Suspected Head and Neck Cancer-2ww-ENT-(DidcotHC)  □ Suspected Head and Neck Cancer-2ww-ENT-(Bicester) | |
|  | **Maxillary Sinus** | |  | Details: |  | |
|  | **Nasal** | |  | Details: |  | |
|  | **Post-Nasal Space** | |  | Details: |  | |
|  | **Hoarseness** | Patient’s Age |  | ≥45 with persistent unexplained hoarseness |  | |
|  | **Tonsil/Tongue Base** | |  | Unilateral sore throat |  | |
|  |  | |  | Unilateral Otalgia |  | |
|  |  | |  | Tonsillar enlargement / ulceration |  | |
| **Neck Lumps**  Persistent unexplained  lump in neck | | |  | No palpable lump, but patient has globus type symptoms or feeling of lump in the throat and there is clinical concern about cancer | **Please select all four clinics for Neck Lump referrals** | |
|  | | |  |  | ✓ Neck Lump-Suspected Head and Neck Cancer-OMFS-(CH) | |
|  | | |  |  | ✓ Neck Lump-Suspected Head and Neck Cancer-OMFS-(JR) | |
|  | | |  |  | ✓ Neck Lump-Suspected Head and Neck Cancer-ENT-(CH) | |
|  | | |  |  | ✓ Neck Lump-Suspected Head and Neck Cancer-ENT-(JR) | |
|  | | |  | Soft tissue lump in the neck or parotid | **Select both direct-to-test FNA clinics OR one of the general clinics if no slots are available**  Answer bleeding risk questions in section below | |
|  | | |  |  | ✓ Neck Lump FNA-Suspected Head and Neck Cancer-2ww-OMFS-(CH) | |
|  | | |  |  | ✓ Neck Lump FNA-Suspected Head and Neck Cancer-2ww-ENT-(CH) | |
| **Oral & Max-Fax Surgery** | **For Oral symptoms NICE recommends urgent dentist referral first but**  **if not practical, use  2-week wait pathway if concerned** | |  | Ulceration in oral cavity > 3 weeks | **Please select both clinics for Oral & Max-Fax Surgery referrals** | |
|  |  | |  | Lump on lip or oral cavity |  | ✓ Suspected Head and Neck Cancer-OMFS-(JR)  ✓ Suspected Head and Neck Cancer-OMFS-(CH) |
|  |  | |  | Red, or red and white, patch in oral cavity consistent with erythroplakia or erythroleukoplakia |  |  |

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| **Management of bleeding risk**  Information required to allow the most patients to move ‘**straight to test**’ prior to OPA  Failure to supply this information may **delay** their progress and result in unnecessary appointments | | | | |
| This patient **IS NOT** anticoagulated |  | | | |
| This patient **IS** anticoagulated with |  | | | |
| Reason for anticoagulation |  | | | |
| Had an INR of |  | | On: | |
| History of bleeding disorder | No | Yes – details: | | |
| For patients who ***are*** anticoagulated and attending a direct-to-test  Fine Needle Aspiration (FNA) clinic appointment | | | | |
| I have advised the patient to stop their **Antiplatelet** therapy (includes Aspirin/Clopidogrel/Ticagrelor)  7 days prior to their appointment | | | |  |
| I have advised the patient to stop their **Warfarin** 5 days prior to their appointment | | | |  |
| I have advised the patient to stop their **Apixaban, Rivaroxaban or Dabigatran** 48 hours prior to their appointment | | | |  |
| It is unsafe to stop the patient’s anticoagulation prior to their appointment | | | |  |

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| Narrative of referral letter / additional information  (please highlight any significant comorbidities) | |
|  | Please tick here if you are sending any additional documents  The referral narrative should be typed onto this form, not in a separate letter |
|  | **Please tick here if the narrative of your referral is in merged consultations below** |
|  | Please tick here if the patient *does not meet* the 2 week wait criteria but you feel they still warrant urgent investigation under this pathway, and outline the details below This referral will then be triaged by the specialist prior to acceptance |
| Please type your clinical referral in the next row | |
|  | |

| **Test Results** | | |
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|  |  | **Entered results** |
|  | Haemoglobin | Date & Result: |
|  | White blood count | Date & Result: |
|  | Neutrophils | Date & Result: |
|  | Lymphocytes | Date & Result: |
|  | Eosinophils | Date & Result: |
|  | Platelets | Date & Result: |
|  | ESR | Date & Result: |
|  | CRP | Date & Result: |
|  | Creatinine | Date & Result: |
|  | Sodium | Date & Result: |
|  | Potassium | Date & Result: |
|  | Calcium | Date & Result: |
|  | eGFR | Date & Result: |
|  | Thyroid function | Date & Result: |

| **Additional patient information** | | |
| --- | --- | --- |
| **Manually entered** | | |
|  | Family history of any cancer | |
|  | Never smoked  Past smoker  Current smoker |  |
|  | Alcohol consumption       units per week | |

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| **Performance Status Key**  (to be **completed by GP** to assist provider with booking an appropriate clinic appointment)  Failure to provide this information may lead to a wasted appointment | | |
| **Fully active**, able to carry on all pre-disease performance without restriction | **0** |  |
| **Restricted in physically strenuous activity** but ambulatory and able to  carry out light/sedentary work, e.g. house or office work | **1** |  |
| Ambulatory and capable of self-care, but **unable to carry out work activities**  Up and active > 50% of waking hours | **2** |  |
| **Capable of only limited self-care**. Confined to bed or chair >50% of waking hours | **3** |  |
| **Completely disabled**. Cannot carry out any self-care. Totally confined to bed or chair | **4** |  |

Consultations

Medication

Problems

Allergies