Musgrove Park Hospital

Yeovil District Hospital NHS Foundation Trust

GP REFERRAL PROFORMA FOR SUSPECTED CANCER
BRAIN & CNS CANCER

PLEASE USE 2WW SERVICE ON CHOOSE AND BOOK OR FAX TO 01823 343 417 (MPH) OR 01935 384 640 (YDH)

This form should only be used for patients who meet the NICE referral criteria for suspected cancer (2005). All other referring symptoms should be referred non-urgently by Choose and Book or letter.

Do not use this form for non-suspected cancer referrals

Decision to refer date *(to be completed by GP)*: Referral received date *(to be completed by hospital)*:

Has the patient been informed that they are being referred for suspected cancer? ☐ Yes ☐ No

Has the patient been given the 2WW referral patient information leaflet? ☐ Yes ☐ No

Please inform the patient that they will be offered an appointment / test within 14 days of receipt of referral

Dates patient is unavailable in next 14 days:

Patient Details:	**Referring GP Details:**
Surname: Forename: Address: Post Code Hosp No: DOB: NHS No: Daytime Tel No: Mobile Tel No: Work Tel No:	Name: Practice: Telephone No: Fax No: E-mail Address:

REFERRAL INFORMATION

☐ Rapidly progressive / subacute neurological deficit developing over days to weeks

☐ New onset seizures characterised by one or more of the following:

- ☐ Focal seizures
- ☐ Prolonged post ictal state
- ☐ Status epiliptus
- ☐ Neurological signs between seizures

☐ Headache, vomiting **and** papilloedema

Please outline symptoms and record any significant medical history, co-morbidities, present medication, recent blood results or any other relevant information.

Please record **WHO PERFORMANCE STATUS**: