

## Suspected Head & Neck Malignancy Referral

THIS FORM SHOULD BE USED TO REFER PATIENTS WHOM THE GP SUSPECTS MAY HAVE HEAD & NECK MALIGNANCY AND WHO REQUIRE AN URGENT CONSULTATION.

THIS FORM SHOULD NOT BE USED FOR ROUTINE REFERRALS PLEASE USE EXISTING REFERRAL DOCUMENTATION FOR ALL OTHER CASES.

### Guidelines for Urgent Referral

- Unexplained tooth mobility not associated with periodontal disease.
- Ulceration of oral mucosa persisting for > 3 weeks.
- Oral swellings persisting > 3 weeks.
- All red or red and white patches of the oral mucosa.
- Dysphagia persisting for 3 weeks.
- Unilateral nasal obstruction particularly when associated with purulent discharge.
- Hoarseness persisting for > 6 weeks.
- Unresolving neck masses for > 3 weeks.
- Cranial neuropathies.
- Orbital masses.

N.B. THE LEVEL OF SUSPICION IS FURTHER INCREASED IF THE PATIENT IS A HEAVY SMOKER OR HEAVY ALCOHOL DRINKER AND IS AGED OVER 45 YEARS AND MALE. OTHER FORMS OF TOBACCO USE (CHEWING BETEL, GUTKHA, PAN) SHOULD AROUSE SUSPICION.

### FAX the reverse side of this referral to:

then SEND original copy to:

Fax	01274 - 382543 01274 - 382544	Fast Track Referral Office Bradford Royal Infirmary Croft Cottage
Telephone	01274 - 382540	29 Smith Lane Bradford BD9 6RJ

**GP Details**

Referring GP

Registered GP (If Different)

Postcode

Telephone

Fax

Daytime telephone number, where patient wishes to be contacted to be offered an appointment.

High index of suspicion discussed with patient &amp; need for urgent appointment

Yes  No **Patient Details**

Surname

Forename

Address

Postcode

Hospital Number (if known)

New NHS Number

Marital Status (please tick) M  S  W  D Sex F  M  date of birth

Telephone (Home)

(Work)

Ambulance Required

Yes  No 

(please tick)

If yes

C1 C2 Str Esc 

Interpreter Required

Yes  No 

Language

**Please Give My Patient An Appointment To See:**

Specialty

Consultant

Specialty Referrals will be allocated the next available appointment in the specialty

**Referral Information**

(please tick boxes)

**Cancer area suspected**Oral Cavity Larynx Pharynx Thyroid **Risk Factor**

Smokers

Yes  No 

Alcohol

Yes  No 

Poor diet

Yes  No **Symptoms**

Hoarseness

Yes  No 

Pain on swallowing

Yes  No 

Dysphagia

Yes  No 

Deafness

Yes  No 

Nasal obstruction/discharge

Yes  No 

Sore throat

Yes  No 

Otalgia

Yes  No 

Bleeding

Yes  No **Clinical Examination**

Oral ulceration/tumour

Yes  No 

Lump in neck

Yes  No 

Thyroid lump

Yes  No 

Orbital mass

Yes  No **Comments/Other Reasons For Urgent Referral****Signature of Referring GP****Date**

