

corporate logo

**Nottingham NHS Treatment Centre**

**Dermatology melanoma**

Z014: Patient referral

If no appointment is available using the e referrals please select defer to provider.

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| **Section 1 Patient information (Please complete in BLOCK CAPITALS)** | | | | |
| Surname:  First name:  Mr  Miss  Mrs  Ms  Other:  Date of birth: | | Date of referral:  NHS number:  UBRN:  Home telephone number: | | |
| Address:    Postcode: | | Mobile / daytime telephone number:  Transport: Yes  No  Mobility:  Interpreter: Yes  No  Ethnicity:  Language: | | |
| **Section 2 Practice information (Please use practice stamp if available)** | | | | |
| Referring GP: | | | | Locum: Yes  No |
| Practice address:    Postcode: | | Telephone:  Fax: | | |
| **Section 3 Clinical information (please ✓all applicable entries)**  **Please enclose print outs of CURRENT medications and PAST MEDICAL HISTORY** | | | | |
| **Characteristics:**        mm (usually >7mm)  **Location:**  Back  Lower leg  Other  Please specify: | **Major features -­‐** 7 point checklist  Change in size  Irregular shape  Irregular colour    **Minor features of lesions:**  Largest diameter 7mm or more  Inflammation  Oozing  Change in sensation | | **Risk factors**  Family history  Multiple naevi  Fair skin / poor tanning  Excessive UV exposure  None | |

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| **Section 4 Past medical history** |
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| **Section 5 Medication** |
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| **Section 6 Additional clinical details** |
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| **Section 7 Performance status** |
| ECOG PERFORMANCE STATUS (please tick one of the following statements about the patient)  0 – Fully active, able to carry on all pre-disease and performance without restriction  1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g light house work, office work  2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours    3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours  4 – Completely disabled. Cannot carry out any selfcare. Totally confined to bed or chair. |

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| Discussed urgent suspected cancer referral with patient: Yes  No |
| Is the patient aware they have been referred on the “2 Week Wait” pathway?: Yes  No |
| Does the patient have any holiday plans within the next 2 months: Yes  No  If yes, please give details below: |

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| Any communication needs |

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| **Hospital use only:** |
| Date referral received: |
| Patient contacted: |

It is important the relevant information sheet is given to the patient when they are referred under the 2ww priority.

The latest patient information sheets were updated in April 2015 in line with NICE guidance. To download the patient information sheets, please click on the link: <http://www.nottinghamchooseandbook.nhs.uk/index.php/county-two-week-wait/17-county-2ww-patient-information-sheets>

Nottingham University Hospitals CircleNottingham

Two Week Wait Office Nottingham NHS Treatment Centre

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