|  |  |  |
| --- | --- | --- |
|  | **High Risk Of Cancer** |  |
| **USC** | **Urgent Suspected Cancer Referral**  **BRAIN CANCER** |
|  |
|  |

**The Central Referral Point Telephone Number is: 01482 604308**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Details** | | | **GP Details** | |
| Name |  | | Name |  |
| DoB |  | | Practice Code |  |
| Address |  | | Address |  |
| Postcode |  | | Postcode |  |
| Tel No. | Home |  | Tel No. |  |
|  | Work |  | Contact Tel No.\* |  |
|  | Mobile |  | \* Direct line of person booking i.e. GP secretary / receptionist | |
| Hospital No. |  | |  |  |
| NHS No. |  | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is patient instructed to self-book? | Yes |  | No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Preferred Contact No. |  | Contact Time |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Is Language Line needed? | Yes |  | No |  | Language Required |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IS THE PATIENT AWARE OF THE POTENTIAL DIAGNOSIS? | Yes |  | No |  |
| Has this patient been seen by a Neurologist before? | Yes |  | No |  |

|  |  |
| --- | --- |
| Name of Consultant |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date Seen |  | / |  | / |  |

|  |  |
| --- | --- |
| Patient’s Name |  |
| Hospital Number |  | |

**History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rapidly Progressive Focal Deficit | * Weakness / heaviness / clumsiness | Yes |  | No |  |
| * Unsteadiness | Yes |  | No |  |
| * Numbness / tingling | Yes |  | No |  |
|  | * Deafness in one ear | Yes |  | No |  |
|  | * Visual disturbance | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Seizures | * Focal Onset | Yes |  | No |  |
|  | * Post-ictal deficit | Yes |  | No |  |
|  | * Associated (inter-ictal) focal deficit | Yes |  | No |  |
|  | * De novo status epilepticus | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Raised Intracranial Pressure | * Headache | Yes |  | No |  |
| * Nausea / vomiting | Yes |  | No |  |
|  | * Double vision | Yes |  | No |  |
|  | * Intermittent drowsiness | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mental State Changes | * Short history cognitive decline (e.g. memory loss) | Yes |  | No |  |
|  | * Short history behaviour / personality change | Yes |  | No |  |

**Examination Findings**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Higher Mental Functions | * Alert | Yes |  | No |  |
|  | * Orientated | Yes |  | No |  |
|  | * Attentive | Yes |  | No |  |
|  | * Forgetful | Yes |  | No |  |
|  | * Dysphasic | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cranial Nerves | * Papilloedema | Yes |  | No |  |
|  | * Extracular Muscle Palsy | Yes |  | No |  |
|  | * Visual Field Loss | Yes |  | No |  |
|  | * Facial Weakness | Yes |  | No |  |
|  | * Unilateral Deafness | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Limbs | * Ataxia | Yes |  | No |  |
|  | * Hemiparesis | Yes |  | No |  |
|  | * Hemisensory Loss | Yes |  | No |  |

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| --- |
| **Medical History / Drugs / Allergies / Other Comments**  (Add additional sheets if required) |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Referral |  | / |  | / |  |