|  |  |  |
| --- | --- | --- |
|  | **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 |[ ]

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

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