



HIGH RISK OF CANCER

2 WEEK WAIT

REFERRAL TO THE NEUROLOGY DEPARTMENT FOR SUSPECTED BRAIN CANCER

PLEASE COMPLETE ALL SECTIONS AND FAX TO **01482 675505**

THE CENTRAL REFERRAL POINT TELEPHONE NUMBER IS 01482 604308

PATIENT DETAILS	GP DETAILS
Name:	Name:
D.O.B.	
Address:	Address:
Post Code:	Post Code:
Tel No:	Tel No:
Hospital No.	Contact No:
NHS No:	<i>(Direct line of person booking ie GP/Secretary/ Receptionist)</i>

Is patient instructed to self book?	Y / N
Contact No:	Contact Time:
Is Language Line needed? Y / N	Language:

IS THE PATIENT AWARE OF THE POTENTIAL DIAGNOSIS? Y / N

Has this patient been seen before by a Neurologist? Y / N

Name of Consultant Date seen:...../...../.....

HISTORY Yes No

PATIENTS NAME.....HOSPITAL NUMBER.....



Rapidly progressive focal deficit

- Weakness/heaviness/clumsiness
- Unsteadiness
- Numbness/tingling
- Deafness in one ear
- Visual disturbance

SEIZURES

- Focal onset
- Post-ictal deficit
- Associated (inter-ictal) focal deficit
- de novo status epilepticus

RAISED INTRACRANIAL PRESSURE

- Headache
- Nausea/vomiting
- Double vision
- Intermittent drowsiness

MENTAL STATE CHANGES

- Short history cognitive decline (e.g. memory loss)
- Short history behavior/personality change

EXAMINATION FINDINGS

Higher mental functions

- Alert
- Oriented
- Attentive
- Forgetful
- Dysphasic

Cranial nerves

- Papilloedema
- Extracular muscle palsy
- Visual field loss
- Facial weakness
- Unilateral deafness

Limbs

- Ataxia
- Hemiparesis
- Hemisensory Loss

MEDICAL HISTORY/DRUGS/ALLERGIES/ANY OTHER COMMENTS:

Signature of G.P..... Date of Referral:/...../.....