**Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office, either via Choose & Book (preferred method) or Email 2 Week Wait form can be downloaded at** [**https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)

|  |  |  |
| --- | --- | --- |
| Name of Provider You Are Referring To: Secondary Care Hospital or Primary Care Dental Access Centre | | |
| Name of Provider:- | | |
| REFERRAL INFORMATION | | |
| This line is for or triaging clinicians only URGENT  ROUTINE | | |
| FULL PATIENT DETAILS | **REFERRER DETAILS** | |
| Mr  Mrs  Miss  Ms  Dr ☐ Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Mobile Number:  E-mail Address: | **Mr  Mrs  Miss  Ms  Dr  Other**  **Surname:**  **First name:**  **Job Title:**  **GDC/GMC Number:**  **Practice Name:**  **Practice Address:**  **Town/City:**  **Postcode:**  **Telephone Number:**  **E-mail Address:** | |
| |  | | --- | | **CLINICAL REASON FOR REFERRAL.**  Please detail reason for referral and what you want us to do for your patient.  ☐ Ulcers (use 2ww form if cancer suspected) ☐ Infection ☐ Soft Tissue Swelling (neck lumps use 2ww form)  ☐ White Lesion ☐ Pigmented Lesion ☐ Bone Lesion  Erosive / Red lesion (use 2ww if cancer suspected)  ☐ Salivary Gland ☐ Pain ☐ Other  Urgent  Routine  **Please attach referral letter if required.** | | **DESCRIPTION OF LESION/CLINICAL FINDINGS:** | | **PROVISIONAL DIAGNOSIS**. Please detail. | | | |
|  | | |
| Clinical Picture | | |
| Kindly attach a relevant good quality image / picture / radiograph for you referral to be accepted. (If unable please provide a reason why to assist triage and acceptance). | | |
| MEDICAL HISTORY | | |
| *Please attach up-to-date medical history form for all referrals – referrals will be returned if this is not included* | | |
| Medical Conditions: Tick box 1 in none. Complete if other  1.No Relevant Medical History confirmed    Current Medication:  Bisphosphonates/Denosumab state no of years……..    Allergies: | **Tick ALL relevant boxes**  Warfarin\*  NOACs e.g. rivaroxaban  Aspirin/Clopidogrel  Bleeding disorders  Bisphosphonates (oral)  Bisphosphonates (IV)  Denosumab  DMARDS (Drugs for rheumatoid conditions)  Oral Steroids  Uncontrolled Diabetes  Valve replacement  Immunosuppressant’s  Chemotherapy | |
| OTHER INFORMATION (E.g. Living arrangements, Legal guardian, Interpreter required) | | |
| PATIENT GP DETAILS *(if not the referrer)* | | **COMMUNICATION & SPECIAL REQUIREMENTS** |
| Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | **Does the patient communicate in a language or mode other than English?**  **YES , please detail. NO**  **Is an interpreter required? YES , please detail. NO**  **Does the patient have any special requirements? YES , please detail. NO** |
| PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT | | |
| Has the patient understood and consented to the referral? YES  NO | | |
| CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER | | |
| I confirm that this patient referral meets the current referral guidelines as issued by the Southwest LDN. (Referral guidelines are available on the LDN website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please note that it is now a mandatory requirement for referrers to provide their GDC or GMC Number on this form Please tick to confirm. | | |
| Print Full Name:………………………………………………………………………………………………… Date:………………………….................  Signature: ……………………………………………………………………………… | | |

**Please return fully completed forms to:**

**Details for where to refer in your region are found at page 21 onward in the Oral Surgery Referral Guidance Document access from the link** [**Here**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)

**Link to the Southwest Oral Surgery Referral Guidance** [**Here**](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2023/05/mcn-oral-surgery-referral-guidelines-for-gdps-March-2023V4.docx)

**For Somerset Primary Care DwSI MOS Referrals Indicate requested provider stating “DAC Bridgwater • Frome • Taunton • or Yeovil”**

**If in doubt, contact your local Oral Surgery Provider.**

**If you feel the case is urgent but not suspected cancer, please contact your local provider in person to discuss.**

**For all suspected cancer cases please use the Relevant 2 Week Wait referral form which can be accessed from the link**

**[Here](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)**