SUSPICIOUS LESION URGENT TWO WEEK PATHWAY ONLY

Age of Patient in years:	Patient's Title & Name:	Gender:	Date of Birth (DD/MM/YY)

Patient's Address:	Preferred Contact Number:	Patient's Postcode:

Dentist Name:	Practice Postcode:	Date of Decision to Refer: / /

Practice Name and Address:	GDC Number:	Practice Telephone Number:

Patients GMP Name and Address:	GMP Postcode:	GMP Telephone Number:

The patient is aware and fully informed regarding the need for the referral:	The patient has been given an information leaflet and a copy of this referral form:	The GMP has been sent a copy of this referral form:
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Culture, Mobility, Impairment Issues:

- ☐ Is the patient from overseas?
- ☐ Is the patient a temporary visitor to the county?
- ☐ Is disabled access required?
- ☐ Is transport required?
- ☐ Visual impairment?
- ☐ Hearing impairment?
- ☐ Translation or interpretation service required?

If yes what language?

Ethnic Origin:

Religion:

Area of Suspicion:

- ☐ Oral cavity
- ☐ Pharynx
- ☐ Thyroid
- ☐ Larynx Neck / lymph node
- ☐ Ear
- ☐ Nose
- ☐ Other

Please state...

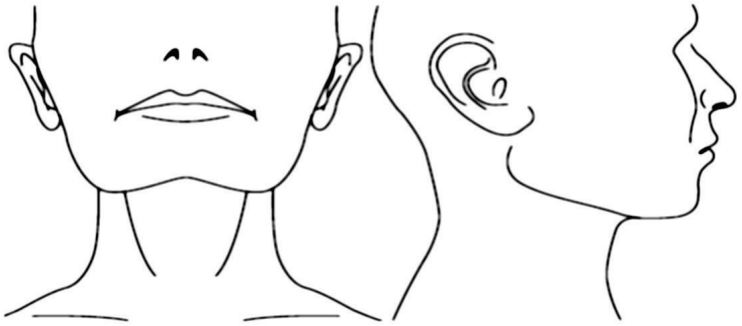
Risk Factors:

- ☐ Poor diet
- ☐ Smoker ☐ How many per day?
- ☐ Ex-smoker ☐ For how long?
- ☐ Alcohol –

No. units per week ☐

- ☐ Paan / Betel Quid / Khat chewing
- ☐ Previous H&N cancer
- ☐ Previous cancer
- ☐ Previous radiotherapy
- ☐ Immunosuppressed
- ☐ HIV/AIDS
- ☐ Human papillomavirus

Figure 1. Please add visual extra oral sign(s) if applicable e.g. lump(s) and or swelling(s):

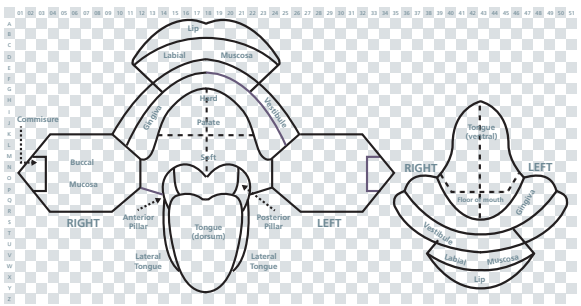


Symptoms:

- ☐ Pain on swallowing
- ☐ Mouth ulcer
- ☐ Unilateral deafness
- ☐ Trismus
- ☐ Sore throat
- ☐ Persistent hoarseness
- ☐ Nasal obstruction/discharge
- ☐ Lump / swelling in neck
- ☐ Bleeding
- ☐ Cranial nerve lesion
- ☐ Orbital mass
- ☐ Otalgia (ear ache)
- ☐ Oral swelling
- ☐ Oral white patch
- ☐ Oral red patch
- ☐ OTHER (Detail below)

Figure 2.

Please add visual intra oral sign(s):



Please provide other relevant information here

Please describe in detail the location of lump(s) and swelling and associated history

Please complete a medical history form and attach to this referral, attach additional information if required

I have read and understand the guide for referrals of this type.

Signed: **Signed:**