Suspected Malignant Lymph Nodes (Below Clavicle)

This form should be submitted via the Referral Support Service

Reference/Priority

Referral Date:	Priority:	NHS Number:
<Specific Referral Out Details>	2WW	<NHS number>

Patient Details

Title:	Forename(s):	Surname:
<Patient name>	<Patient name>	<Patient name>
Date of Birth:	**Gender:**	**Ethnicity:**
<Date of birth>	<Gender>	<Ethnicity>

Contact Details

Address Line 1:	Address Line 2	Address Line 3:
<Patient address>	<Patient address>	<Patient address>
Town:	**County:**	**Postcode:**
<Patient address>	<Patient address>	<Patient address>
Phone:	**Mobile:**	**Text Message Consent:**
<Patient Contact Details>	<Patient Contact Details>	No
Email:		
<Patient Contact Details>		

Referrer/Practice Details

Referring Name:	Referrer Code:	Practice Code:
<Specific Referral Out Details>	<Specific Referral Out Details>	<Organisation Details>

Referral Details

Specialty:	Clinic Type:	Named Clinician:
2WW	2WW Breast	

Patient Choice Preferences

Provider 1:	Provider 2:
<Recipient details>	

Preferences

Assistance Required:	Assistance Notes:	Confidential/Silent Referral:
No		No
Preferred Contact Time:	**Interpreter Required:**	**Preferred Language:**
	No	<Main spoken language>

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Referral Details

Non-clinical information for the booking team:

Provisional Diagnosis:

<Specific Referral Out Details>

Smoking Status Readcode:

<Diagnoses>

Referral Reason/Letter Text

<Specific Referral Out Details>

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If your patient does not meet any of the NICE defined 2WW criteria please liaise (by phone or Advice and Guidance) with a specialist or send them in as an urgent referral. Please do not annotate 2WW forms with your own criteria.

Patient Awareness

Confirm that your patient understands that they have been referred onto a "suspected cancer pathway":	Unknown
Confirm that your patient has received the information leaflet	Unknown
Confirm that your patient is available to attend an appointment within 2 weeks of this referral:	Unknown

If, after discussion, your patient chooses to not attend within 2 weeks, when will they be available:

Referral Information

For Suspected malignant lymph nodes **above clavicle** – refer by using Suspected **Maxillofacial / Head & Neck Cancer** Referral Form (category "unexplained and persistent lump/ mass in neck")

For suspected malignant lymph nodes in patients with **previous breast cancer** – refer by using Suspected **Breast Cancer** Referral Form

Condition Details (tick appropriate boxes)

Why are there concerns about these lymph nodes? Please specify:

Site of suspected malignant lymph node (tick appropriate boxes)

Axilla	☐
Groin	☐
Other, please specify:	☐

Family History

<Family History(table)>

Active Problems

<Problems(table)>

Summary

<Summary(table)>

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Significant Past

<Problems(table)>

Current Repeat Medication

<Medication(table)>

Acute Medication (last 3mths)

<Medication(table)>

Measurements

BP (last 3):
<Last 3 BP Reading(s)(table)>

Weight (last 3):
<Numerics>

Height (last 3):
<Numerics>

BMI (last 3):
<Numerics>

Oxford Knee Score (last 3):
<Numerics>

Allergies

<Allergies & Sensitivities(table)>

Lab Results

<Pathology & Radiology Reports(table)>