North Thames Children and Young People's Cancer Network

CCN Initial Referral Protocol

Relevant Children's Cancer Measure: 14-7A-115

Created:	May 2010	**Version:**	2.0
Last Updated:	May 2015	**Status:**	Active
Review Date	2 years or sooner in light of new developments		
Author:	Dr Nicholas Goulden – Consultant Haematologist / PTC Lead Clinician		
Executive Lead(s)	Darren Hargrave – Chair of NTCCNCG		

Initial Referral Protocol for Children/Adolescents with Symptoms and Signs of Malignancy

1 Background

1.1 Cancer in Children/Adolescents

Prompt recognition of the diagnosis and early referral for initiation of specialist management is integral to the excellent outcome of childhood cancer. Children/adolescents with malignancy may present to a wide variety of clinicians including, general practitioners, surgeons, paediatricians and accident and emergency departments. This document describes the referral pathway to be followed by any clinician who suspects a diagnosis of cancer in a child/adolescent within the North Thames Region.

1.2 Organisation of Children's Cancer Services in North Thames

In line with national structures, specialist care for children with cancer is coordinated by the departments of Paediatric and Adolescent Oncology at GOSH and UCLH which act as the Principal Treatment Centre for North Thames. The PTC is responsible for finalising the diagnosis and determining the treatment plan. Treatment is then delivered by the PTC in partnership with a local Paediatric oncology shared care unit (POSCU). http://www.gosh.nhs.uk/medical-information/clinical-specialties/haematology-and-oncology-information-parents-and-visitors/referral-information-haematology-and-oncology-department

2 Referral Pathway

All children/adolescents with a suspected malignancy should be referred to their local POSCU - with the exception of suspected primary bone tumours, which are referred directly to the Royal National Orthopaedic hospital (www.londonsarcoma.org). See separate sarcoma referral pathway.

The POSCU is equipped to provide initial assessment and then facilitate direct referral to the appropriate PTC. The contact details of the North Thames POSCUs are detailed on the London Cancer Website: http://www.londoncancer.org/media/86487/childrencontacts.pdf and on page 6 of this document, on the referral form.

Specific referral guidelines can be found here:
http://www.londoncancer.org/media/86490/childrensguidelines.pdf

All Haematology and Oncology referrals need to come with a minimum dataset form – see attachments on pages 5 to 8.

This information is needed in order to ensure that the Haem/Onc department is compliant with referral to treatment pathways and that appropriate information is supplied for Haem/Onc MDTs.

The rationale of all parts of the minimum data set form is described below:

2.1 Referring hospital

This will allow the Trust to share pathways and breaches with referring hospitals when appropriate.

2.2 Cancer Pathway information

Cancer pathway information will ensure that the Haem/Onc department can correctly identify where on the cancer pathway the patient is and allows the identification of patients that fall into the 'two – week wait' category.

2.3 Referral information

Referral information allows for accurate recording of clock starts and stops and enables the Trust to identify where on the 18 week pathway the referred patient is.

2.4 Diagnostic information

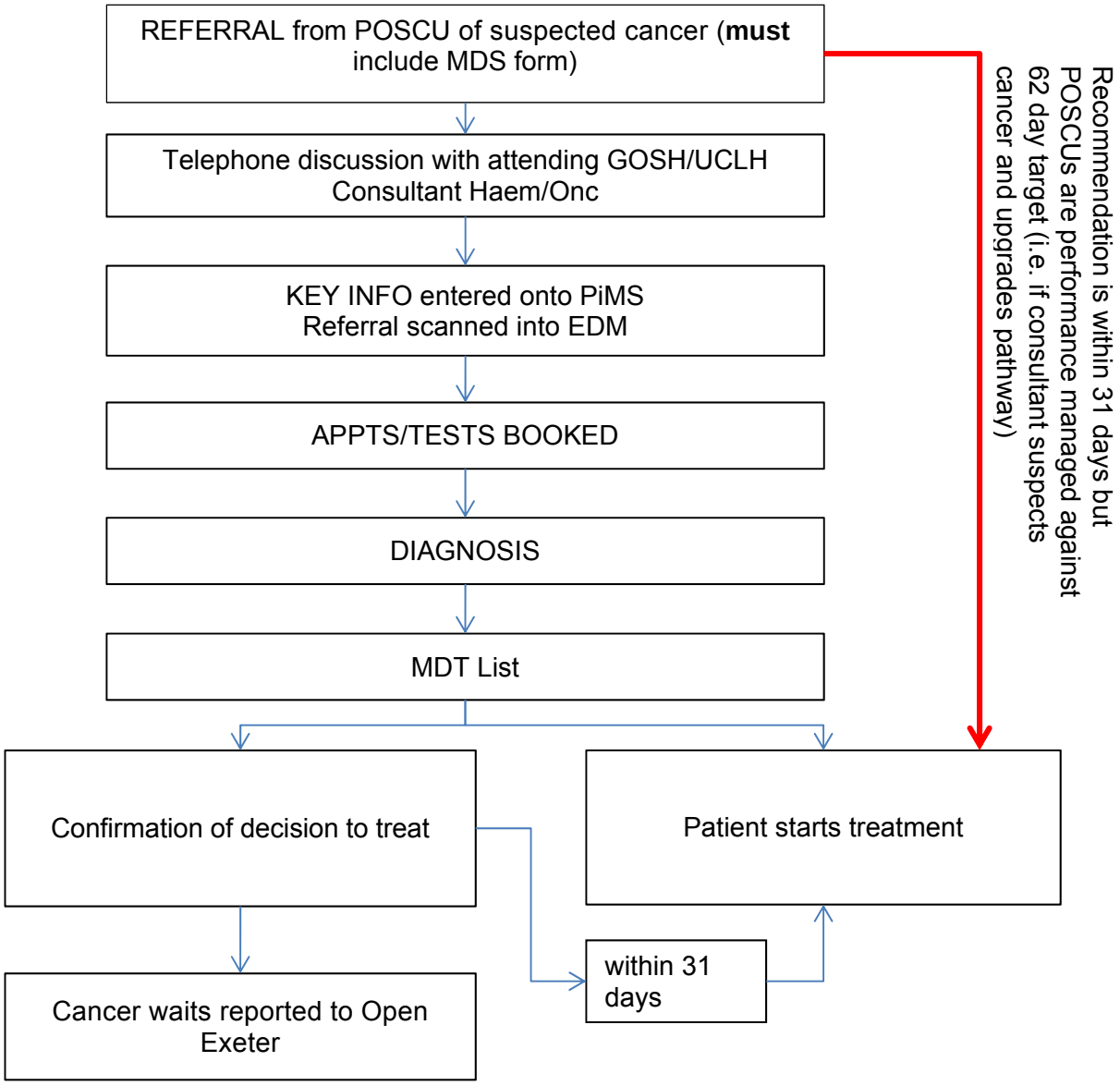
This information will ensure that appropriate clinical information is available at the relevant MDT

meeting. The minimum data set form must be faxed alongside the referral form/letter by referring Trusts. . Information about any clinical investigations carried out by the referring centre should be added to the form where relevant, and sent to the PTC for the relevant MDT to review.

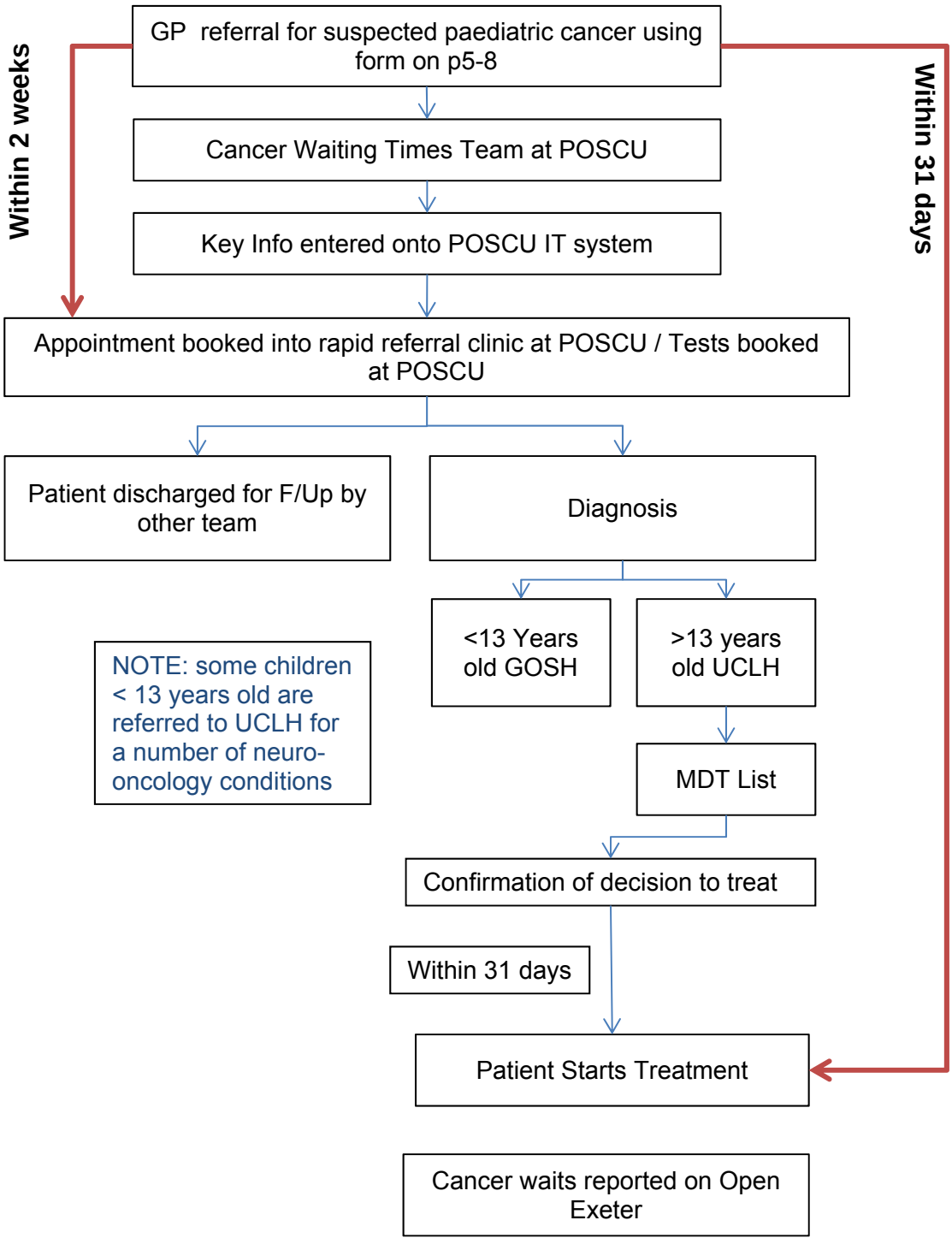
2.5 Timing of Referral

It is important to note that **all children/adolescents, regardless of clinical condition, with a suspected malignancy should be discussed with the POSCU** on the day that the concern is raised. In line with the Department of Health HSC 2000/13 referral guidelines, and the subsequent NICE clinical guideline CG027, all children/adolescents with a suspected malignancy must be reviewed by the PTC within 14 days, although most are seen much sooner.

3 HAEM / ONC POSCU REFERRAL PROCESS



4 HAEM / ONC GP REFERRAL PROCESS



PAEDIATRIC SUSPECTED CANCER REFERRAL

Great Ormond Street Hospital for Children NHS Trust

To make a referral to the Great Ormond Street Hospital (GOSH) Haematology/Oncology Department, please fax this form to the appropriate contact (as below) with an accompanying referral letter detailing family history, medical history and current medication.

For all referrals being made within working hours (Monday-Friday, 09.00 to 17.00) please fax to the appropriate contact below:

- Haematology – 020 7813 8410
- Oncology – 020 7813 8588

For clinically urgent inpatient referrals being made out of hours or on weekends, please fax to the number below:

- Lion/Elephant Ward – 020 7813 8265

Date referral sent: …….....
Type of Referral: □ Urgent □ Non-Urgent
Name of GOSH consultant to whom referral is being made: ……..

The Patient:	**Referral Information: *Must be completed***
Surname: First Name: Address: Postcode: DOB: _ _ /_ _ _/ _ _ _ _ Male/Female Ethnicity: Name and relationship of person with Parental Responsibility: ……..... OR Name and relationship of main carer: ……..... Home Telephone No: Work Telephone No: Mobile No: Eligible for NHS Treatment: YES ☐ NO ☐ NHS No (REQUIRED if applicable): Is transport required? YES ☐ NO ☐ Is an interpreter required? If yes, which language?	**See pathways – some children will need admission instead of an OP referral** Has the patient been referred to your centre on a 2 week wait suspicion of cancer referral? YES ☐ NO ☐ Has the patient previously visited GOSH? YES ☐ NO ☐ GOSH Hospital Number *(if known)*: **Diagnostic imaging performed at your centre prior to this referral?** YES ☐ NO ☐ If yes please provide details of tests with dates …… …… …… **Imaging being sent to GOSH** YES ☐ NO ☐ *(Please IEP images to anna.blackshaw@gosh.nhs.uk)* **Pathology testing carried out** YES ☐ NO ☐ If yes please provide details of tests with dates …… …… …… **Pathology Sent to GOSH:** YES ☐ NO ☐
The Referring Centre: GP / Hospital / Other: Name of Clinician: Name of Centre: Address: Postcode: Tel No: Fax No: Name of Centre MDT Coordinator: Clinician Signature:	**Patient's General Practitioner (if not the referring Clinician)** Name of GP: Name of Practice: Address: Postcode: Telephone number: Fax number:

North and East London Error! Reference source not found. **(patients aged under 19 yrs)** (Version: MSW1; 25/02/2015)

Press the <Ctrl> key while you here to VIEW REFERRAL GUIDELINES

REFERRAL DATE:

Press the <Ctrl> key while you click here to VIEW LEAD CLINICIAN CONTACT INFORMATION

To refer, phone the relevant LOCAL Paediatric Lead Clinician. Then fax or email this form. The local paediatric team will refer the patient to the age-appropriate tertiary paediatric oncology centre if cancer is strongly suspected. You can also send a letter with it or type in the additional information text entry box located on page 3 (press the <Ctrl> key while you click here to go to this box)

Please X the corresponding box for the hospital the referral is being made to and fax/send within 24 hours

Hospital	Phone	Fax	Email: select & copy OR <Ctrl>+click
☐ Barnet & Chase Farm	0208 216 5418	0208 216 4138	
☐ Basildon	01268 593 630	01268 598 066	
☐ Chelmsford	01245 515206	01245 516751	
☐ Chelsea & Westminster	0203 315 2026	0203 315 8814	
☐ Hillingdon	01895 279 263	01895 279 807	
☐ Newham	0207 363 9390	0207 363 8081	paedpod@bartshealth.nhs.uk
☐ North Middlesex	07436 283 463	020 887 2932	
☐ North West London Hospitals	0208 235 4200	0208 8235 4188/9	
☐ Princess Alexandra	01279 827 550	01279 827 171	
☐ Queen's Hospital (BHRUT)	01708 435 172	01708 435 074/367	
☐ Southend	01702 385 180	01702 385 882	
☐ St Mary's Hospital (ICHT)	0203 311 15 27/28/30/31	0203 312 1580	2WWSMH@imperial.nhs.uk
☐ The Royal London	0207 767 3333	0203 594 3278	
☐ UCLH	0203 447 9599	0203 447 9932	uclh.2ww@nhs.net
☐ Watford & Hemel	01727 897 171/199	01727 897 492	
☐ Whipps Cross	0208 539 5522 extensions 4348/4349/4350	0208 928 8836	
☐ Whittington	0207 288 5869	0207 288 5629	
☐ For suspected bone sarcomas please contact the Royal National Orthopaedic Hospital Tel: 020 8909 5603 Fax: 020 8909 5709			

☐ **Patient has previously visited selected hospital** **HOSPITAL No:**

PATIENT DETAILS
SURNAME: FIRST NAME: TITLE:
GENDER: DOB: NHS NO:
ETHNICITY: LANGUAGE:
☐ INTERPRETER REQUIRED ☐ TRANSPORT REQUIRED
PATIENT ADDRESS: POSTCODE:
DAYTIME CONTACT☏:
HOME☏: MOBILE☏: WORK☏:
EMAIL:

GP DETAILS
USUAL GP NAME:
PRACTICE NAME:
PRACTICE ADDRESS: PRACTICE CODE:
BYPASS☏:
MAIN☏: FAX: EMAIL:
REFERRING CLINICIAN:

CLINICAL DETAILS

Please Note: Some children will need emergency admission instead of an OP referral

DIAGNOSIS SUSPECTED

- ☐ Leukaemia
- ☐ Lymphoma
- ☐ Brain Tumour
- ☐ Soft Tissue Sarcoma
- ☐ Bone Tumour
- ☐ Wilm's Tumour
- ☐ Neuroblastoma
- ☐ Retinoblastoma
- ☐ Hepatoblastoma
- ☐ Other (please specify):

SYMPTOMS

General

- ☐ Weight Loss
- ☐ Fatigue/malaise/lethargy
- ☐ Fever
- ☐ Pallor or other signs of anaemia

Pain

- ☐ Bone Pain
- ☐ Abdominal Pain
- ☐ Headache
- ☐ Other pain (please specify):

Neurology

- ☐ Fits
- ☐ Weakness
- ☐ Dysphagia
- ☐ Ataxia
- ☐ Facial Nerve Palsy
- ☐ Torticollis
- ☐ Other (please specify):

Behavioural

- ☐ Behavioural change
- ☐ Deterioration in school performance

EXAMINATION

- ☐ Skin lesions/oedema
- ☐ Abdominal mass
- ☐ Soft tissue mass
- ☐ Chest signs
- ☐ Lymphadenopathy
- ☐ Hepatomegaly
- ☐ Splenomegaly
- ☐ Nerve Palsy
- ☐ Other (please specify):

Additional information:

Any other relevant symptoms or signs not covered by the guidelines:

Duration of symptoms:

Family history of cancer including age at diagnosis:

- ☐ I confirm that I have discussed the possibility that the diagnosis may be cancer with the child and/or guardian
- ☐ I confirm that I have explained the two week wait appointment process to the child and/or guardian

Please hand the patient a copy of the URGENT REFERRALS PATIENT INFORMATION LEAFLET

Press the <Ctrl> key while you click here to view the leaflet

PAST MEDICAL HISTORY

ALLERGIES

MEDICATION