Western Sussex Hospitals NHS
NHS Foundation Trust

2 Week Rule Referral - Children aged Sixteen and under

Patient Details	
Name: Address: Daytime Telephone: Work Telephone Mobile Telephone:	Date of Birth: Sex: M/F NHS Number: Hospital Number: ☐ Please indicate by ticking the appropriate ☐ box(es) which number(s) the patient can ☐ be contacted on during the next 24 hours
GP Details	
GP Name: **Practice:** **Date of Referral:**	**Telephone Number:** **Fax Number:**
Social circumstances	
Lives alone ☐	Is a carer for someone ☐ Has a care package ☐

Please refer to the Network Referral Guidelines for Suspected Cancer in Children and Young People if you suspect a child aged Sixteen or younger may have cancer. Please phone and discuss with the relevant consultant before faxing this form.

I think the above child may have a malignancy because:

I discussed this child with
on DATE:

Current Medication

Relevant PMH

Additional Information

Please state if you are attaching a computer printout of this information Yes/No

Reference: NICE referral guidelines for suspected cancer June 2005
©These referral proformas were developed by The Local Referral and Management Guidelines Team
Western Sussex Hospitals NHS Trust, St Richard's Hospital. Chichester

All 2 week rule appointments for WSHT are managed and booked by the Worthing Hospital 2 week rule team.

Please Fax this form to 01903 285098 or email it to
cancer.appointments@nhs.net