

## Guideline for the Provision of Skin Cancer Services in the Community

### Version History

Version	Date	Summary of Change/Process
1.0	21/07/09	Endorsed by the Governance Committee Guidelines Review Sub Group
2.1	02/03/10	With changes made by Shireen Velangi
2.1	17/03/10	Discussed at the guidelines review sub group of the governance committee – further changes recommended.
2.2	22/03/10	Early review requested to clarify the position of BCCs and urgent referral.
2.3	2/06/10	Review taking into account the NICE guidelines of May 2010 regarding the management of low-risk basal cell carcinomas in the community
2.4	18/12/10	Updated following discussions at Skin Network Site Specific Group
2.5	30/03/10	Reviewed by Clinical Governance Group
3.0	30/03/10	Endorsed by the Governance Committee Guidelines Review Sub Group

<b>Date Approved by Network Governance</b>	<b>30 March 2011</b>
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<b>Date for Review</b>	<b>30 March 2014</b>
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### Summary of changes made between version 1 and version 2

- *Scope now includes referral to secondary care services*
- *Appendices 1 and 2 added for clarification*
- *Section 3.3 was added*
- *Clarification over the actions to take regarding aggressive BCCs (3.4)*
- *Additional clarity to section 3.5*

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## 1. Scope of the Guideline

This document describes:

- a) The arrangements for the provision of community skin cancer services.
- b) Criteria for community skin cancer practitioners for the management of low-risk basal cell carcinomas.
- c) Referral criteria for patients with suspected skin cancer to secondary care services.

## 2. Guideline Background

2.1 In February 2006, the National Institute for Health and Clinical Excellence (NICE) published service guidance on skin cancer<sup>1</sup>. Many of the recommendations were converted into peer review measures. An exceptional update was issued by NICE in May 2010 to specifically address the management of low-risk Basal Cell Carcinomas (BCC) in the community<sup>2</sup>.

2.2 In Pan Birmingham Cancer Network, treatment for skin cancers in the community is currently provided by acute Trust clinicians, acting under the governance of the acute Trust as part of that hospital's dermatology outreach service.

With the exception of the removal of BCCs, there are currently no community skin cancer services operating under the governance arrangements of the individual Primary Care Trusts.

2.3 PCTs are required to inform the Cancer Network in writing whenever a new provider of community skin cancer services is engaged. Should a new provider to community skin cancer service be engaged they will be required to follow this Network Guidance.

2.4 Following the NICE guidance of May 2010<sup>2</sup> patients may, where appropriate, have their treatment provided by one of three different groups of healthcare professional in primary care:

- a. **GPs performing skin surgery:** within the framework of the Directed Enhanced Services and Local Enhanced Services under General Medical Services (GMS) or Personal Medical Services (PMS). This is **for low-risk BCCs only (see Box 1, appendix 1)**. The responsibility for governance arrangements for this service rests with the commissioning Primary Care Trust.
- b. **Model 1 practitioner** – (As defined in the 'Manual for cancer services 2008: skin measures'). These practitioners are 'Group 3 GPwSI in dermatology and skin surgery' as defined by the Department of Health guidance, and include a new 'GPwSI in skin lesions and skin surgery' (**see Box 2, appendix 1**). The responsibility for governance arrangements for this service rests with the commissioning Primary Care Trust.

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- c. **Model 2 practitioners** – (As defined in the 'Manual for cancer services 2008: skin measures'). These are outreach community skin cancer services provided by acute trusts linked to the Local Skin Multi Disciplinary Team (LSMDT) (**see Box 3, appendix 1**). Governance arrangements for this service lie with the acute Trust providing the service.

**All other types of skin cancer or suspected skin cancer should be referred as per the primary care referral guideline (section 5 below)**

### 3. Guideline Statements

3.1 PCTs will ensure that any new service providers (practitioners) for the management of low-risk basal cell carcinoma satisfy the criteria laid out in **Box 1, appendix 1** (for GPs within the framework of the Direct Enhanced Service and Local Enhanced Service under General or Personal Medical Services), or **Box 2** (for Model 1 Practitioners).

#### 3.2 DES/LES Practitioners (Box 1)

According to this model those GPs working within the framework of the DES/LES under GMS or PMS services should:

- a) Demonstrate competency in skin surgery
- b) Have specialist training in the recognition and diagnosis of skin lesions appropriate to their role
- c) Send ALL specimens removed to histology for analysis
- d) Provide quarterly feedback to their Primary Care Trust on histology reported
- e) Provide details to their Primary Care Trust of all types of skin cancer removed in their practice and should not knowingly remove skin cancers other than low-risk BCCs
- f) Attend, at least annually, an educational meeting (organised by the Skin Network Site Specific Group)

#### 3.3 Model 1 Practitioners (Box 2)

According to this model those GPwSIs practising as Model 1 practitioners should:

- a) Be accredited by Primary Care Trusts according to national guidance appropriate to their role as GPwSIs
- b) The GPwSI is linked to a named skin cancer LSMDT and attends four LSMDT meetings per year
- c) Clinical governance arrangements lie with the PCT
- d) CPD requirements are specified in the dermatology and skin surgery GPwSI guidance<sup>3</sup>
- e) Attend, at least annually, an educational meeting (organised by the Skin Network Site Specific Group)
- f) Provide evidence of an annual review of clinical compared with histological accuracy in diagnosis of the low-risk BCCs they have managed

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### 3.4 Model 2 Practitioners (Box 3)

These are core MDT members providing a community outreach service and sit within the governance framework of a designated acute trust. If there is an overlap between Model 1 practitioners and Model 2 practitioners then provided there is a documented link with an acute Trust/hospital governance arrangement in addition to their Primary Care Trust governance arrangement these practitioners may work as both a Model 1 practitioner and a Model 2 practitioner. This would entitle them to excise the full range of skin cancers (other than 'hospital only' procedures) provided the patient has been discussed and the management plan agreed with a core member of the Multi Disciplinary Team.

## 4. Monitoring and Training

### 4.1 Monitoring of Community Practitioners

- a) The Governance arrangements of the GPs working within the framework of the DES/LES under General or Personal services and the Model 1 GPwSI is the responsibility of the commissioning PCT
- b) The lead clinician of the MDT will monitor GPwSIs adherence to Model 1 practitioners' requirements related to the Local Skin MDT
- c) Notification will come from the skin laboratories to the referring GP when a biopsy result identifies a malignant excision. The laboratory will also inform the relevant skin MDT. The responsibility for referral of the patient rests with the GP unless other local arrangements have been agreed

### 4.2 Training for Community Practitioners

- a) Community practitioners wishing to excise low-risk BCCs in the community are required to undergo training appropriate to their role. This is outlined in **Boxes 1, 2 and 3 in appendix 1**

The NSSG has identified named trainers and assessors for GPs wishing to operate as community practitioners and Primary Care Trust's may approach these clinicians regarding the commissioning of these teaching services. These are as follows:

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Name	Role	Local / Specialist Skin MDT
Dr Samantha Beswick	Consultant Dermatologist	Burton Hospital NHS Trust LSMDT
Dr Peter Carwright	Consultant Dermatologist	Burton Hospital NHS Trust LSMDT
Dr Jai Bhat	Consultant Dermatologist	Heart of England NHS Foundation Trust SSMDT (Good Hope Site)
Dr Irshad Zaki	Consultant Dermatologist	Heart of England NHS Foundation Trust SSMDT (Solihull Site)
Dr Camilo Diaz	Associate Specialist (with CCST) in Dermatology	Sandwell and West Birmingham Hospitals NHS Trust LSMDT
Mr Atul Khanna	Consultant Plastic Surgery	Sandwell and West Birmingham Hospitals NHS Trust LSMDT
Dr Saj Rajpar	Consultant Dermatologist	University Hospital Birmingham NHS Foundation Trust SSMDT
Mr Shivram Singh	Consultant Plastic Surgeon	University Hospital Birmingham NHS Foundation Trust SSMDT
Dr Abhijit Banerjee	Consultant Dermatologist	Walsall Hospital NHS Trust LSMDT
Mr Atul Khanna	Consultant Plastic Surgery	Walsall Hospital NHS Trust LSMDT
Dr Phil Preston	Consultant Dermatologist	Worcester Hospital NHS Trust LSMDT
Dr Bill Tucker	Consultant Dermatologist	Worcester Hospital NHS Trust LSMDT

## 5. Primary Care Referral Guidelines

Where Community Practitioners are not accredited to undertake skin cancer services, then the primary care referral guidelines (below) should be adhered to:

- a) Actinic keratoses and precancerous lesions may be dealt with by any GP
- b) GPs should refer suspected cases of skin cancer requiring treatment, EXCLUDING BCCs, to their local skin cancer MDT, using the urgent 2 week wait referral form (**appendix 4**)
- c) Basal Cell Carcinomas may be referred to the appropriate provider in line with the algorithms for referral and management of low risk BCC. (**appendix 3**) Referrals to the LSMDT should be written in the normal way (via letter) and booked using partial or complete booking

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## Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2013.

## References

1. Improving outcomes for People with Skin Tumours Including Melanoma: the manual – 2006. Available from <http://guidance.nice.org.uk/CSGSTIM/Guidance/Standard2006/pdf/English>
2. NICE Guidance on Outcomes for People with Skin Tumours including Melanoma (update) – May 2010. Available from <http://guidance.nice.org.uk/CSGSTIM/Guidance/pdf/English>
3. Department of Health (2007) Guidance and competencies for the provision of services using GPs with special interests (GPwSIs): dermatology and skin surgery. Available from [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074665](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074665)
4. National Cancer Peer Review Programme (2008) Manual for cancer services 2008: skin measures. Available from [www.ncpr.nhs.uk/index.php?menu=resources](http://www.ncpr.nhs.uk/index.php?menu=resources)
5. National Institute for Health and Clinical Excellence (2005) Improving outcomes in children and young people with cancer. Available from [www.nice.org.uk/CSGCYP](http://www.nice.org.uk/CSGCYP)
6. The Primary Medical Services (Directed Enhanced Services) (England) Directions 2006 Available from [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4136870.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136870.pdf)
7. National Cancer Peer Review Programme (2008) Manual for cancer services 2008: skin measures. Available from [www.ncpr.nhs.uk/index.php?menu=resources](http://www.ncpr.nhs.uk/index.php?menu=resources)
8. Department of Health (2007) Implementing care closer to home: convenient quality care for patients. Part 3: the accreditation of GPs and pharmacists with special interests. London: Department of Health. Available from [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074430](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074430)

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## Authors

Shireen Velangi – Chair of the Pan Birmingham Skin NSSG  
Ben Parfitt – Associate Director of the Pan Birmingham Cancer Network

**Approval Date of Network Site Specific Group** Date: December 2010

**Approval Date of the Governance Committee** Date: March 2011

## Approval Signatures

### Pan Birmingham Cancer Network Governance Committee Chair

Name: Doug Wulff

Signature:



Date: 04 April 2011

### Pan Birmingham Cancer Network Manager

Name: Karen Metcalf

Signature:



Date: 04 April 2011

### Network Site Specific Group Clinical Chair

Name: Shireen Velangi

Signature:



Date: 04 April 2011

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## Appendix 1 Different Models of Provider for Skin Cancer Services<sup>1</sup>

### Box 1 – Low Risk BCCs for DES/LES

#### Services for the removal of low risk nodular BCCs that can be commissioned from GPs within the framework of the DES and LES under General or Personal Medical Services

Services should be commissioned from these GPs where there is no diagnostic uncertainty that the lesion is a primary nodular low risk BCC and it meets the following criteria:

The patient is not:

- aged 24 years or younger (that is, a child or young adult)
- immunosuppressed or has Gorlin's syndrome.

The lesion:

- is located below the clavicle (that is, not on the head or neck)
- is less than 1cm in diameter with clearly defined margins
- is not recurrent BCC following incomplete excision
- is not a persistent BCC that has been incompletely excised according to histology
- is not morphoeic, infiltrative or basosquamous in appearance
- is not located:
  - over important underlying anatomical structures (for example, major vessels or nerves)
  - in an area where primary surgical closure may be different (for example, digits or front of shin)
  - at another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient.

If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be superficial BCC the GP should ensure that the patient is offered the full range of medical treatment (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

Incompletely excised BCCs should be discussed with a member of the LSMDT.

#### Criteria for accreditation of GPs within the framework of the DES and LES under General Practitioner or Personal Medical Services

GPs performing skin surgery on low risk BCCs within the framework of the DES and LES under General or Personal Medical Services should:

- demonstrate competency in performing local anaesthesia, punch biopsy, shave excision, curettage and elliptical excision using the direct observation of procedural skills (DOPS) assessment tool in the Department Health Guidance for GPwSIs in dermatology and skin surgery and then follow a program of revalidation
- have specialist training in the recognition and diagnosis of skin lesions appropriate to their role
- send all skins specimens removed to histology for analysis
- provide information about the site of excision and provisional diagnosis on the histology request form
- maintain a 'fail safe' log of all their procedures with histological outcome to ensure that patients are informed of the final diagnosis, and whether any further treatment or follow-up is required
- provide quarterly feedback to their PCT or LHB on the histology reported as required by the national skin cancer minimum dataset, including details of all proven BCCs
- provide details to their PCT or LHB of all types of skin cancer removed in their practice as described in the 2006 NICE guidance on skin cancer services and should not knowingly remove skin cancers other than low risk BCCs
- provide evidence of an annual review of clinical compared with histological accuracy in diagnosis for the low risk BCCs they have managed
- attend at least annually, an educational meeting (organised by the Skin Cancer Network Site Specific Group) which should:
  - present the 6 monthly BCC Network audit results, including a breakdown of individual practitioner performance
  - include one CPD session (a total of 4 hours) on skin lesion recognition and the diagnosis and management of low risk BCCs
  - be run at least once a year with an additional meeting to be arranged with the local team.

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## **Box 2 – Model 1 Practitioners**

### **Low risk BCCs that can be operated on by Model 1 practitioners in the community (existing ‘Group 3 GPswI in dermatology and skin surgery’ and new ‘GPswI in skin lesions and skin surgery’)**

Services should be commissioned from Model 1 practitioners for the management and excision of low risk BCC where the definition of a low risk BCC is made after excluding the following.

Patients who are:

- aged 24 years or younger (that is, a child or young adult)
- immunosuppressed or have Gorlin’s syndrome

Lesions that:

- are on the nose and lips (including nasofacial sulci and nasolabial folds), or around the eyes (periorbital) or ears
- are greater than 2cm in diameter below the clavicle or greater than 1cm in diameter above the clavicle unless they are superficial BCCs that can be managed non-surgically
- are morphoeic, infiltrative or basosquamous in appearance
- have poorly defined margins
- are located:
  - over important underlying anatomical structures (for example, major vessels or nerves)
  - in an area where primary surgical surgery closure may be difficult (for example, digits or front of shin)
  - in an area where excision may lead to poor cosmetic result.

If any of the above exclusion criteria apply, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be superficial BCC the GP should ensure that the patient is offered the full range of medical treatment (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

### **Criteria for accreditation of Model 1 practitioner by PCTs or LHBs**

GPswIs performing skin surgery as ‘Group 3 GPswI in dermatology and skin surgery’ should follow the framework for the training and accreditation of Model 1 practitioners, which is defined by the Department of Health as follows:

- they are accredited by PCTs or LHBs according to national guidance appropriate to their role as GPswIs
- the GPswI is linked to a named skin cancer LSMDT and attends four LSMDT meetings per year, skin cancer clinical practice is audited annually as defined in the dermatology and skin surgery GPswI guidance
- clinical governance arrangements are with the PCT or LHB and the GPswI meets the continuing professional development requirements for community skin cancer clinicians specified in the dermatology and skin surgery GPswI guidance

In addition they should:

- provide evidence of an annual review of clinical compared with histology accuracy in diagnosis of the low risk BCC they have managed
- at least annually, an educational meeting (organised by the Skin Cancer Network Site Specific Group) which should:
  - present the 6 monthly BCC Network audit results, including a breakdown of individual practitioner performance
  - include one CPD session (a total of 4 hours) on skin lesion recognition and the diagnosis and management of low risk BCCs
  - be run at least twice a year.

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### **Box 3 - Model 2 Practitioners**

#### **Criteria for accreditation of Model 2 practitioners**

Model 2 practitioners should sit within acute trust clinical governance framework and should:

- be trained in and have demonstrated competency in skin surgery techniques (as per SS1 and SS2 framework in the GPwSI guidance)
- be associated with a named LSMDT
- perform surgery on pre diagnosed skin cancers, receiving referrals from a member of the LSMDT with an agreed treatment plan.

If they are 'Group 3 GPwSI in dermatology and skin surgery' then they should provide evidence of annual review of clinical compared with histological accuracy in diagnosis of the low risk BCCs they have managed.

GPs should attend, at least annually, an educational meeting (organised by the Skin Cancer Network Site Specific Group), which should:

- present 6-monthly BCC Network audit results, including a breakdown of individual practitioner performance
- include one CPD session (a total of 4 hours) on skin lesion recognition and the diagnosis and management of low risk BCCs
- be run at least twice a year.

**Appendix 2 – Acceptable Models for the Management of Skin Cancer in the Community (as defined in the ‘Manual for Cancer Services 2008: Skin Measures’)**

Under PCT Governance	Under Acute Trust Governance	
Model 1	Model 2	Model 3
<p>Dermatology GPwSI</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of low risk BCCs (care level 2)</li> <li>• Receives referrals for this from any other medical practitioner</li> <li>• Training and accreditation is the responsibility of the PCT, according to group 3, GPwSI training – DH guidance</li> <li>• Practitioners associated with a named skin cancer MDT</li> </ul>	<p>Surgery only, by nurse surgical practitioner or medical practitioners, not a core MDT member, but fulfilling the following:</p> <ul style="list-style-type: none"> <li>• Carrying out any skin cancer surgical excision other than ‘hospital only’ procedures (measure 08-2J-213), at MDT’s discretion</li> <li>• Receiving referrals only from core MDT members, only of previously diagnosed patients with agreed treatment plans</li> <li>• Trained in competencies for skin cancer surgery (DH – SS1, SS2 competencies) or exempt (measure 08-1C-117j)</li> <li>• Associated with a named MDT, under its clinical governance</li> </ul>	<p>Core MDT members, community outreach Service</p> <ul style="list-style-type: none"> <li>• Diagnosis and management of skin Cancer</li> <li>• Delivering treatment in the Community</li> <li>• Training is covered by conventional specialty training in dermatology, and practitioners are subject to the MDT measures for core members in the Manual for Cancer Services</li> </ul>

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### Appendix 3 – Algorithm for Referral Management of Low Risk BCC Low Risk BCCs for DES/LES

Patient with skin lesion presents to GP: thought to be a low risk BCC

Does the GP meet the requirements to perform skin surgery within the framework of the Direct Enhanced Services and Local Enhanced Services under General Medical Services or Personal Medical Services? Has the GP demonstrated surgical competency?

NO

REFER to a member of the LSMDT

YES

Is GP confident of the diagnosis of a low risk BCC?

NO

REFER to a member of the LSMDT

YES

There is no diagnostic uncertainty that the lesion is a primary nodular low risk BCC and it meets the following criteria:

- **The patient is not:**
  - aged 24 years or younger (that is, a child or young adult)
  - immunosuppressed or has Gorlin's syndrome
- **The lesion:**
  - is located below the clavicle (that is not on the head or neck)
  - is less than 1cm in diameter with clearly defined margins
  - is not a recurrent BCC following incomplete excision
  - is not a persistent BCC that has been incompletely excised according to histology
  - is not morpheic, infiltrative or basosquamous in appearance
  - is not located:
    - over important underlying anatomical structures (for example, major vessels or nerves)
    - in an area where primary surgical closure may be difficult (for example, digits or front of shin)
    - in an area where difficult excision may lead to a poor cosmetic result
    - at another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient.

If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be superficial BCC the GP should ensure that the patient is offered the full range of medical treatments available (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

Incompletely excised BCCs should be discussed with a member of the LSMDT.

Criteria Met?  
NO

REFER to a member of the LSMDT

Criteria met? YES

Manage low risk BCC appropriately

Primary Care Trust Governance

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# Algorithms for Referral/Management of Low Risk BCC – Model 1 and Model 2 Practitioners

## Primary Care Trust Governance

### Model 1 – Practitioner

Patient referred to accredited Model 1 practitioner ('Group 3 GPwSI in dermatology and skin surgery' or new 'GPwSI in skin lesions and skin surgery') with a suspected low-risk BCC

Services should be commissioned from Model 1 practitioners for the management and excision of low-risk BCC where the definition of low-risk BCC is made after excluding the following:

- **Patients who are:**
  - aged 24 years or under (that is, a child or young adult)
  - immunosuppressed or have Gorlin's syndrome
- **Lesions that:**
  - are on the nose and lips (including nasofacial sulci and nasolabial folds), or around the eyes (periorbital) or ears
  - are greater than 2cm in diameter below the clavicle or greater than 1cm in diameter above the clavicle unless they are superficial BCCs that can be managed non-surgically
  - are morphoeic, infiltrative or basosquamous in appearance
  - have poorly defined margins
  - are located
    - over important anatomical structures (for example, major vessels or nerves)
    - in an area where primary surgical closure may be difficult (for example, digits or front of shin)
    - in an area where excision may lead to a poor cosmetic result.

If any of the above exclusion criteria apply, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be superficial BCC the GP should ensure the patient is offered the full range of medical treatments (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

Incompletely excised BCCs should be discussed with a member of the LSMDT.

Confirmed low risk BCC

Manage appropriate

## Acute Trust Governance

### Model 2 – Practitioner

Unable to confirm low risk BCC

Is the 'Group 3 GPswI in dermatology and skin surgery' also a **Model 2** practitioner?

NO

REFER to a member of the LSMDT

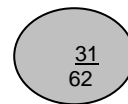
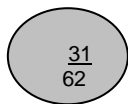
YES

Discuss patient's low risk BCC with a core member of the LSMDT and agree management plan

Manage low risk BCC appropriately

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# Appendix 4 – 2 Week Wait Referral Form



## URGENT REFERRAL FOR SUSPECTED SKIN CANCER (Version 2.0)

If you wish to include an accompanying letter, please do so. **On completion please FAX to the number below.**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

### Patient Details

### GP Details (inc. Fax Number)

Surname		
Forename		
D.O.B.		Gender
Address		
Postcode		Fax No:
Telephone		<b>Date of Decision to Refer</b>
NHS No		<b>Date of Referral</b>
Hospital No		<b>GP Signature</b>
Interpreter? Y / N		First Language:

### Suspected Diagnosis: (Check relevant boxes)

Use the following 7-point checklist for pigmented skin lesions:

**Melanoma:**

Location .....

Size of lesion .....

**Major Features: (2 points each)**

Change in size

Irregular shape

Irregular colour

**Minor Features: (1 point each)**

Largest diameter 7mm or more

Inflammation

Oozing

Change in sensation

**Squamous cell carcinoma:**

Location .....

Size of lesion .....

**Characteristics:**

Non-healing keratinizing

Crusted with significant induration

Documented expansion over 8 weeks

New/growing cutaneous lesion

Histological diagnosis of SCC – include histology report with fax

**Risk factors:**

Immunosuppression

### Clinical Details: do not use this form for patients with suspected BCC

History/Examination/Investigations.....

Medication .....

### For Hospital Use

Appointment Date Clinic Attending

Was the referral appropriate Yes No (if no please give reason)

### SKIN CLINICS WITH RAPID ACCESS FACILITIES

Hospital	Tel	Fax
Burton Hospital	01283 566333	01283 593090
City Hospital	0121 507 5805	0121 507 5075
Good Hope Hospital	0121 424 7476	0121 424 7376
Solihull (HoEFT)	0121 424 5000	0121 424 5001
Sandwell Hospital	0121 507 3834	0121 507 3723
Queen Elizabeth (UHBFT)	0121 627 2485	0121 460 5800
Walsall Manor Hospital	01922 721172 ext 7110 or 7785	01922 656 773
Worcester Hospitals	01905 763333	01562 754312

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