Moorfields Eye Hospital

Suspected Lid, Orbital or Conjunctival Cancer Referral Form

Fax to: 020 7566 2073

To make a referral, FAX this form to Moorfields Booking Centre within 24 hours of the decision to refer. You may also fax an accompanying letter if you wish to do so.

This form should NOT be used for suspected basal cell carcinomas which should be referred to the Eyelid Oncology Service at Moorfields Eye Hospital in the usual way.

The PATIENT:

SURNAME:
FIRST NAME:

NHS NO (required):

ADDRESS:

DOB:
TEL NO:
WORK NO:
MOBILE NO:
Is an interpreter required? If yes, which language?

Is transport required? Y / N

The REFERRING GP:
NAME:
PRACTICE NAME:

PRACTICE NUMBER:
ADDRESS:

TEL NO:
FAX NO:

The REFERRING CONSULTANT:
NAME:
ORGANISATION:

ADDRESS:

TEL NO:
FAX NO:

Is patient on an open cancer pathway? Y / N

If Y: 31 day ☐ 62 day ☐

Breach date (if known):

N.B. If this is a confirmed cancer referral from secondary care the inter-provider transfer form must also be provided

REFERRAL INFORMATION *must be completed*

DIAGNOSIS: Has patient been informed of diagnosis? Y / N

Lid tumour ☐ Orbital tumour ☐ Conjunctival tumour ☐

Probable ☐ Possible ☐ Definite ☐

Lid Tumour

Malignant melanoma ☐ Squamous cell carcinoma/ other ☐

Duration (months): Size (mm): Site (draw):

R L

Malignant melanoma:		Squamous cell carcinoma/ other:	
Growing in size	Y / N	Crusty/ not healing	Y / N
Changing shape	Y / N	Bleeding	Y / N
Changing colour	Y / N	Growing in size	Y / N
Inflamed	Y / N	Palpable lymph nodes	Y / N
Ulceration/bleeding	Y / N	Organ transplantation	Y / N
Palpable lymph nodes	Y / N	Immunosuppressive therapy	Y / N

Orbital tumour

Site: Right ☐ Left ☐

Symptoms:	
Vision loss/ change	Y / N
Diplopia	Y / N
Proptosis/ globe displacement	Y / N

Duration (months):

CT/ MRI Y / N
Previous biopsy Y / N

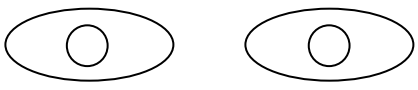
If Y diagnosis:

Conjunctival tumour

Symptoms: Red eye Y / N; Non-resolving conjunctivitis Y / N

Symptom duration (months):

Site (draw): R L



Previous biopsy or surgery Y / N

If Y diagnosis: