

Treatment section

To be completed by the Specialist or referring General Practitioner

Please provide the name and address of the hospital where the treatment took place

Hospital name

Hospital address

Town or city

County

Postcode

Where is the primary site of the cancer?

What was the date of diagnosis?

Is the patient's mouth cancer related, in any way, to HIV infection or AIDS? Yes No

Does the treatment relate to tests or consultations for non-invasive tumours? Yes No

On what date did the patient first become aware of the symptoms?

Please describe the treatment provided

Please describe any further treatment that may be planned

Medical practitioner's declaration

I declare that I am the patient's Specialist (or General Practitioner), that the patient was referred to me by his/her General Practitioner, and that the information given is, to the best of my knowledge, true and correct.

Name

Signature

Date

Title

Are you a Consultant Maxillofacial Surgeon? Yes No

If 'No' please give details

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