



Queensland Government



Queensland Youth Cancer Service Referral

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex M F Indeterminate

**For referring young patients (aged 15 - 25 years) with a diagnosis of cancer
SERVICE HOURS: Monday to Friday 8.00am - 4.30pm**

Date:

Name of Referrer:

Referrer's phone:

Referrer: Patient Parent / Carer Medical Registered Nurse Allied Health Other

Patient contact:

Phone:

Address:

Email:

Diagnosis:

New Relapse

Date of diagnosis / relapse:

Treating Specialist:

Treatment centre:

Patient's consent obtained for referral? Yes No

Doctor's consent obtained for referral? Yes No

PLANNED TREATMENT

Chemotherapy? Yes No Protocol: _____

Radiation? Yes No Radiation field: _____

Surgery? Yes No Site: _____

GP details:

REASON FOR REFERRAL

Social work: _____

Psychology: _____

Fertility preservation: _____

Education, vocation, career: _____

Other: _____

SUBMIT

or scan and send to QYCS_CHQ@health.qld.gov.au

QUEENSLAND YOUTH CANCER SERVICE USE ONLY

RBWH LCCH PAH TTH GCUH Mater Central team

Staff member accepting referral:

ACTION TAKEN:

Clinician to follow-up: Clinical Nurse Consultant Social Worker Psychology Lead Clinician

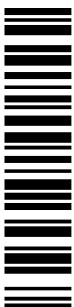
Staff member responsible:

Signature:

Scanned into patient record Date responded:

DO NOT WRITE IN THIS BINDING MARGIN

v5.00 - 08/2017



SW539