Queensland Government

YOUTH CANCER SERVICE

# 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

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