Cancer Society Auckland Northland - Supportive Care Referral

Please send referral to Supportive Care:

AUCKLAND: Fax: 09 308 0175 | Email: supportservices@akcansoc.org.nz

NORTHLAND: Fax: 09 437 5602 | Email: northland@akcansoc.org.nz

Please tick service(s) required: ❑**Community Liaison Nursing*** ❑**Counselling & Psychology** ❑**Volunteer Driving**

Please note: Supporting clinical documentation is required for Community Liaison Nursing – please attach to this referral

ALL REFERRALS – PLEASE COMPLETE ALL FIELDS

DATE: .....

Has the person being referred agreed to contact by the Cancer Society?: ❑Yes ❑No

Can Cancer Society staff leave a phone message saying who they are?: ❑Yes ❑No

Please fill in details, or attach patient information label:

Surname: ..... **First Name/s:** ..... **Title *(eg Mr/Mrs)*:** .....

Address: ..... **Post Code:** .....

..... **DOB:** ..... **NHI Number:** .....

Cell Phone: ..... **Home Phone:** ..... **Work Phone:** .....

NZ Resident: ❑ Yes ❑ No **Ethnicity:** ..... **Speaks English:** ❑ Yes ❑ No

REFERRER INFORMATION:

Name: ..... **Location:** ❑ ACH ❑ Other .....

Position: ..... **Department:** .....

Email: ..... **Phone No:** .....

Cancer Diagnosis: ..... **Date of Diagnosis:** .....

Treatment (PLEASE COMPLETE FOR ALL SERVICES):

❑ Surgery: ..... Surgeon: .....

❑ Chemotherapy: ..... Medical Oncologist: .....

❑ Radiation Therapy: ..... Radiation Oncologist: .....

Other Medical History: .....

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Reason for Referral (PLEASE COMPLETE FOR ALL SERVICES): .....

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GP Name: ..... **GP Organisation:** .....

Other Agencies Involved: .....

COUNSELLING & PSYCHOLOGY REFERRALS ONLY:

Is the person being referred a cancer patient? ❑Yes ❑No

If no, please indicate relationship i.e. spouse/partner, friend, family etc. .....

VOLUNTEER DRIVING REFERRALS (PLEASE COMPLETE ALL FIELDS WHERE POSSIBLE)

First Appointment: *(Up to **5 working days** may be needed to arrange drives)*

Date: ..... Time: .....

Location of appointments: ❑ ACH ❑ Other.....

Radiotherapy Appointment Schedule:

No. of Weeks: ..... Estimated Finish Date: .....

Chemotherapy Appointment Schedule:

Estimated duration of appointments: ❑ Less than 1 hour ❑ 1-2 hours ❑ 2-4 hours ❑ More than 4 hours

Mobility: ❑ Fully mobile ❑ Not fully mobile .....

Other Information (e.g. Mental health, seizures).....

Processing of this referral may be delayed if:

- **All required fields have not been completed accurately.**
- **There is insufficient supporting clinical documentation (*For Community Liaison Nursing).**