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| Logo, icon  Description automatically generated  Queensland  Youth Cancer Service Referral  Facility: | URN:  Family name:  Given names:  Address: |  | |
| DOB: |  | Sex:  M  F  I |
| |  |  |  | | --- | --- | --- | | **For referring young patients (aged 15-25 years) with a diagnosis of cancer. SERVICE HOURS: Monday to Friday 9.00am – 4.30pm** | | | | **Patient contact:**       **Phone:** | | | | **Patient address:** | | | | **Patient 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 | | | | **Patient has consented to be contacted?**  Yes  No | | | | **Previous medical conditions or treatment history:** | | | | **Planned treatment:**  Chemotherapy  Radiation  Surgery **Estimated End of Treatment date:** | | | | **GP details:** | | | | **Reason for psychosocial referral:**  Social work:  Psychology:  Fertility preservation:  Other: | | | | **Relevant psychosocial history:** | | | | **Distress:**  Tick the number (0-10) that best describes how much distress the young person has been experiencing in the past week.  **NO DISTRESS**  0  1  2  3  4  5  6  7  8  9  10 **EXTREME DISTRESS** | | | | **Fertility Preservation** | | | | Was the young person given written/verbal information about potential effects on fertility? | **Yes**  **No** | If *no*:  Young person declined  Treatment not likely to affect fertility  Unable to proceed due to disease | | Was the young person referred to a fertility specialist? | **Yes**  **No** | If *no*:  Young person declined  Treatment not likely to affect fertility  Unable to proceed due to disease | | Did the young person undertake fertility preservation? | **Yes**  **No** | If *yes*: Method of preservation:  If *no*:  Young person declined  Treatment not likely to affect fertility  Unable to proceed due to disease | | **Referrer’s name:**       **Referrer’s phone:** | | | | **Date of referral:** | | | | **Please scan to** [**QYCS@health.qld.gov.au**](mailto:QYCS@health.qld.gov.au) | | | | | | |