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| Logo, icon  Description automatically generated QueenslandYouth Cancer Service ReferralFacility:       | URN: Family name: Given names:Address: |                      |
| DOB: |       | Sex: [ ]  M [ ]  F [ ]  I |
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| **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** |

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