REFERRAL - LIFT CANCER SERVICES

Thank you for your referral. Lift Cancer Care Services will assess your patient and provide treatment as clinically indicated
For questions please call (08) 7231 8000 from 8am - 5pm, Monday - Friday

Please print or complete electronically and fax to (08) 7200 3108 (please include 08 at the start of fax number)

DATE OF REFERRAL	☐ The patient is aware that this referral has been made and has consented to this referral
REFERRING DOCTOR	DIAGNOSIS
Please affix patient label here	BONY METASTASES Y / N Location:

SIGNIFICANT MEDICAL HISTORY		
☐ Hypertension	☐ Diabetes	☐ Cardiovascular disease
☐ Hypotension	☐ Arthritis	☐ Asthma / COPD
☐ Anxiety / Depression	☐	☐
☐	☐	☐

SURGERY		
Has the patient had surgery? ☐ YES	Date of surgery	Surgeon
Procedure	Nodes removed?	

CHEMOTHERAPY	
Current / Planned / Ceased	Regime
Date of most recent infusion	
Date of next infusion	

RADIOTHERAPY	
Current / Planned / Ceased	Regime
Dates	

HORMONE TREATMENT	
Current / Planned / Ceased	Name of medication
Significant side effects	

TREATMENT INTENT
Curative / positive / unclear / palliative
If palliative, are palliative care supports in place?
Details

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Lift Cancer Care Services

CLINICAL SERVICES REQUIRED
MULTI-DISCIPLINARY SCREENING ASSESSMENT
☐ Patient is likely to require multiple services, please provide with a multi-disciplinary screening assessment

OR as individually indicated below

EXERCISE MEDICINE		
☐ Cancer related fatigue	☐ Reduce cancer recurrence	☐ Improve body composition
☐ Assist with weight management	☐ Assist management of treatment side effects	☐ Assist with treatment completion
☐ Other (please detail)		
CLINICAL PSYCHOLOGY		
☐ Elevated score on distress thermometer	☐ Patient has asked to see psychologist	
☐ Other (please detail)		
DIETETICS		
☐ Weight loss/malnutrition	☐ Diagnosed with pancreatic ca / head & neck ca / oesophageal ca / liver ca	
☐ Loss of appetite or reduced intake	☐ Rx side effects – dry mouth, mouth sores, nausea, vomiting, taste change	
☐ PEG / NGT planned or recently inserted	☐ Patient concerned about unexplained increase in weight	
☐ Other (please detail)		
SPEECH THERAPY		
☐ Recurrent aspiration pneumonia	☐ Difficulty swallowing	☐ Limited jaw movement
☐ Speech/language difficulties	☐ Diagnosed with head & neck ca / oesophageal ca	
☐ Other (please detail)		
MEN'S HEALTH PHYSIOTHERAPY		
☐ Urinary Incontinence	☐ Erectile dysfunction	☐ Peyronies's Disease
☐ Rehab following surgery (please detail)		
☐ Other (please detail)		
PHYSIOTHERAPY		
☐ Musculoskeletal injury	☐ Pain management	☐ Functional limitation
☐ Rehab following surgery (please detail)		
☐ Other (please detail)		
LYMPHOEDEMA SCREENING		
☐ Surgery with lymph node dissection	☐ Radiotherapy to pelvis/breast/axillary/internal mammary/subclavian nodes	
☐ Patient concerned about developing lymphoedema		
LYMPHOEDEMA TREATMENT		
☐ Patient has diagnosed cancer related lymphoedema, please assess and treat as required		

ANY OTHER IMPORTANT INFORMATION
Please provide other addional information below if required, or attach