Referral Form

The YCS provides medical, nursing and psychosocial support for adolescents and young adults (15-25 years) with a recent diagnosis of cancer.

Patient Information		
Name:	DOB:	MRN No:
Gender: ❑ male ❑ female ❑ other (please advise):		
Country of birth:	Preferred language:	
❑ Interpreter required (male/female):	❑ Aboriginal ❑ Torres Strait Islander ❑ both	
Street address: Suburb: Postcode:		
Phone home:	Mobile:	Email:

Emergency contact/Next of kin	
Full name:	Relationship:
Contact number:	Email:
Has patient provided consent to share information with this person? ❑ Yes ❑ No ❑ Unknown	

Patient's General Practitioner		
Name:	Phone:	Fax:

Diagnosis and Treatment Information	
Date of diagnosis:	Diagnosis:
❑ new diagnosis ❑ relapse/recurrence ❑ other:	
Current treatment:	
Is patient participating in a clinical trial? ❑ Yes ❑ No ❑ Unknown	
Name/number of trial:	

Treating Team	
Doctor name:	Contact number:
Treating hospital:	❑ Public ❑ Private

Referral Details		
Name:	Position:	
Phone:	Mobile:	Email:
Reason for referral:		
Referrer signature:		Date:
Is the patient aware of this referral to the NSW-ACT Youth Cancer Service? ❑ Yes ❑ No		

Please return this form to your nearest NSW-ACT Youth Cancer Service

Newcastle	e: CHC-CalvaryMater-AYACCN@health.nsw.gov.au	f: 02 4014 4747
Sydney (Randwick)	e: SESLHD-SydneyYCS@health.nsw.gov.au	f: 02 9382 5170
Westmead	e: wslhd-westernsydneyycs@health.nsw.gov.au	f: 02 9845 2171
RPAH/Sarcoma (Camperdown)	e: sarcomaaya@lh.org.au	f: 02 9383 1014
ACT	e: chs.aya@act.gov.au	f: 02 5124 2887

Office Use Only

Date received: Staff member: Date of initial patient contact: