



CANCER SUPPORT REFERRAL FORM

Client Medtech ID: _____
Staff Name: _____
Staff Designation: _____

THIS SERVICE IS FOR ALL MĀORI PATIENTS AND THEIR WHĀNAU WHO LIVE WITHIN THE AUCKLAND DISTRICT HEALTH BOARD BOUNDARY

PATIENT DETAILS

NHI _____ Date of Birth _____ Age _____
First Name _____ Last Name _____ Gender: Male / Female
Address _____ Suburb _____ City _____
Contact Phone _____

(Stick label above if present)

Diagnosis (and Date of initial diagnosis if known):

Reason for referral:

(Circle option or fill in the spaces)

Are the patient and Whānau aware of diagnosis? : Yes / No
Is the patient currently on treatment? : Yes / No
Do the patient and Whānau agree to this visit? : Yes / No
The Patient Lives with: Spouse / Other Whānau / Alone

Are there any other community support services involved in this care?
Cancer Society / District nurses / Hospice / Other (specify) _____

Is the Patient English speaking? Yes / No
Does the patient require an interpreter? Yes / No If Yes, which language: _____

SAFETY PRECAUTIONS

Are there dogs on the premises _____
Do you have a locked gate? (do we need to call when we arrive to have gate opened) _____

REFERRER / GP DETAILS

Date _____ Referrer Name _____ Place of Work _____
Designation/Title _____ Contact Phone Number _____
GP's Name _____

Cancer Support Nurse
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