nova scotia health authority
Nova Scotia Cancer Care Program

Community Cancer Patient Navigation Referral

Patient's Name _____

Health Card Number _____**Mobile Phone (if applicable)** _____

Diagnosis _____

Treatment/Expected Treatment _____

_____

Physician(s) _____

Consent for Referral given by patient. Yes □

Patient type: □Suspected Diagnosis □New Diagnosis □Recurrence □ Progression □Long term follow-up

Reason for referral (Please check all appropriate boxes)

□	Medication Coverage	□	Poor prognosis
□	Requires supportive care	□	Pain and Symptom management
□	Financial issues	□	No family support
□	Very anxious/distressed	□	Coordination issues
□	Travel Issues	□	Teaching required

Comments_____

_____

_____

Distress Screen: □ Yes □ No Screen Saved in HPF □ Yes □ No

Other referrals made: □ Social Work □ Drug Access Navigator □ Palliative Care □ Other _____

Navigator Location: _____

Date _____**Referred By (please print)**: _____

Signature: _____**Phone #:** _____

Please send referrals to:

NZ please email to: NZpsychosocialoncology@nshealth.ca

WZ please email to: CancerCareProgramYRH@nshealth.ca

EZ please email to: CPNReferralEZ@nshealth.ca