COMMUNITY CANCER PATIENT NAVIGATION REFERRAL FORM

Patient's Name: _____

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

Diagnosis: _____

Treatment/Expected Treatment: _____

_____

Health Care Provider(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
❑ Requires supportive care
❑ Financial issues
❑ Very anxious/distressed
❑ Travel issues
❑ Poor prognosis
❑ Pain and symptom management
❑ Limited supports
❑ Coordination issues
❑ Education needs

Comments: _____

_____

_____

_____

_____

Other Referrals Made: ❑ Social Work ❑ Drug Access Navigator ❑ Palliative Care ❑ Other

Date (YYYY/MON/DD): _____ **Referred By (please print):** _____

Signature: _____ **Phone Number:** _____

Please send referrals to:

Northern Zone (NZ) please email to: NZpsychosocialoncology@nshealth.ca

Western Zone (WZ) please email to: WZPSO@nshealth.ca

Eastern Zone (EZ) please email to: CPNReferralEZ@nshealth.ca