nova scotia health authority
Cancer Care Program

CONFIDENTIAL FAX

Cancer Patient Navigation Referral

Patient's Name _____

Phone _____ **Date of Birth** ____/____/___

Health Card Number _____ **OPIS Number** _____

Diagnosis _____

Treatment _____

Physician (s) _____

Is the patient aware this referral is being made? □ **Yes** □ **No**

Patient type: □ Pre 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 Scanned in HPF** □ Yes □ No

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

Signature: _____ **Phone #:** _____

Navigator's name: _____ **Fax Number:** _____