

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)

- | | |
|---|--|
| <input type="checkbox"/> Medication Coverage | <input type="checkbox"/> Poor prognosis |
| <input type="checkbox"/> Requires supportive care | <input type="checkbox"/> Pain and Symptom management |
| <input type="checkbox"/> Financial issues | <input type="checkbox"/> No family support |
| <input type="checkbox"/> Very anxious/distressed | <input type="checkbox"/> Coordination issues |
| <input type="checkbox"/> Travel Issues | <input type="checkbox"/> 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: WZPSO@nshealth.ca

EZ please email to: CPNReferralEZ@nshealth.ca