



Provincial Health Services Authority

EXTERNAL REFERRAL FORM SUPPORTIVE CANCER CARE

Addressograph

Issue being addressed must be related to cancer

BC Cancer Centre: Abbotsford Kelowna Prince George
 Surrey Vancouver Victoria

Referral Date: _____

Patient's Name: _____ DOB: _____ DD / MM / YYYY PHN: _____

Referring Physician/NP/Clinician: _____ Referrer's : _____

Diagnosis: _____

Is the patient/family aware of the referral? Yes No Interpreter required? Yes* No *Language _____

Does the patient have a known history of violence/aggression? Yes No

NUTRITION

Referral Criteria: BC Cancer registered patient experiencing weight loss and/or difficulty eating. For patients with informational needs related to cancer and nutrition, or general nutrition refer patients to HealthLink BC (8-1-1)

Patient's height: _____ and weight: _____ Date measured: _____

Reason for Referral (check *all* that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Pre-treatment Consult | <input type="checkbox"/> Impaired intake due to: | <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> Malnutrition risk | <input type="checkbox"/> anorexia | <input type="checkbox"/> pain |
| <input type="checkbox"/> Tube feeding | <input type="checkbox"/> diarrhea | <input type="checkbox"/> partial bowel obstruction |
| <input type="checkbox"/> Unintentional Weight Loss. | <input type="checkbox"/> dysphagia | |
| Weight loss amount _____ | <input type="checkbox"/> mucositis | |
| Timeframe of weight loss _____ | | |
| <input type="checkbox"/> Other: _____ | | |

PAIN & SYMPTOM MANAGEMENT/PALLIATIVE CARE referral form [click here](#).

PATIENT & FAMILY COUNSELLING (PFC)

Referral Criteria: Cancer diagnosis/Patient or family member/From diagnosis to 18 months post acute treatment/Requiring practical or emotional support for coping with cancer.

Reason for Referral (check *all* that apply):

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Accommodation | <input type="checkbox"/> Depression | <input type="checkbox"/> Parenting support | <input type="checkbox"/> Chinese Language Counselling |
| <input type="checkbox"/> Adjustments to diagnosis/treatment | <input type="checkbox"/> Family / relationships | <input type="checkbox"/> Stress management | <input type="checkbox"/> Punjabi Language Counselling |
| <input type="checkbox"/> After treatment concerns | <input type="checkbox"/> Financial & practical assessment | <input type="checkbox"/> Transportation to cancer appointments | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Grief / loss | <input type="checkbox"/> Work related | |

PSYCHIATRY

Referral Criteria: Cancer diagnosis/Patient or family member/From diagnosis to 12 months post acute treatment.

*Emergency services (e.g. patient at imminent risk for suicide) or patients with a significant risk of physical aggression are not eligible. Please follow local processes for patients who require emergency care. Psychiatrists do not see patients for medico-legal purposes.

Does this patient: see a psychiatrist or other mental health care professional in the community?	Yes	No
If yes, specify profession: _____	<input type="checkbox"/>	<input type="checkbox"/>

Reason for Referral (check *all* that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Deteriorating mental health condition | <input type="checkbox"/> Neurocognitive disorder |
| <input type="checkbox"/> Major depression | <input type="checkbox"/> Refusing treatment / unable to attend treatment due to mental health problems | <input type="checkbox"/> Personality changes and/or behavioral changes |
| <input type="checkbox"/> *Suicidal ideation | <input type="checkbox"/> Dementia | <input type="checkbox"/> Aggressive cancer significantly affecting mood |
| <input type="checkbox"/> Diagnostic assessment | | Provide additional information in the comments. |

SPEECH LANGUAGE PATHOLOGY

Referral Criteria: Person with cancer from diagnosis through post treatment who is experiencing swallowing or communication difficulties as a results of their cancer or cancer treatment, including post-surgery (e.g. glossectomy, laryngectomy).

Reason for Referral (check *all* that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Pre-treatment Consult | <input type="checkbox"/> Voice | <input type="checkbox"/> Trismus |
| | <input type="checkbox"/> Speech | <input type="checkbox"/> Head and neck lymphedema |
| | <input type="checkbox"/> Communication | <input type="checkbox"/> Swallowing/dysphagia |

OTHER SUPPORTIVE CANCER CARE PROGRAMS

- | | | |
|--|---|--|
| <input type="checkbox"/> Art Therapy
FAX 604-877-6249 | <input type="checkbox"/> Spiritual Health
FAX 604-851-4718 | <input type="checkbox"/> Vocational Rehabilitation
FAX 604-877-6249 |
|--|---|--|

Incomplete referrals will not be processed. Please fax Page 1 and Page 2.

	WITH YOUR FAX, PLEASE INCLUDE: <ul style="list-style-type: none"> COVER PAGE WITH NUMBER OF PAGES BEING SENT A CONFIDENTIALITY WARNING 			
BC Cancer Centre	Nutrition	PFC	Psychiatry	SLP
Abbotsford	604-851-4718	604-851-4718	604-851-4718	604-851-4872
Kelowna	250-712-3987	250-712-0090	250-712-3987	250-862-4207
Prince George	250-645-7381	250-645-7381	250-645-7381	250-645-7381
Surrey	604-930-4015	604-930-4015	604-930-4015	604-585-5568
Vancouver	604-877-6120	604-877-6249	604-877-6249	604-877-6435
Victoria	250-519-2011	250-519-2011	250-519-2011	250-429-3633

			
BC Cancer Centre	Nutrition	PFC and Psychiatry	Speech Language Pathology
Abbotsford	604-851-4733	604-851-4733	604-302-8657
Kelowna	250-712-3963	250-712-3963	Services provided by Interior Health Authority 250-862-4000 ext 7327
Prince George	250-645-7330	250-645-7330	250-645-7330
Surrey	604-930-4000	604-930-4000	Services provided by Surrey Memorial Hospital 604-585-5666 x 778318.
Vancouver 604-877-6000	Ext: 672013	Ext: 672194	Ext: 67-6268
Victoria	250-519-5525	250-519-5525	250-519-5770