|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WAPOS sees public patients or those accessing some of their cancer care in the public system.**  **Patient Details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname | |  | | | | | | | | | | | | | | First Name | | | | | | | |  | | | |
| Aboriginal/  Torres Strait Is | | Yes/No | | | | | | | | | Preferred Pronouns | | | | |  | | | | | | | | D.O.B | |  | |
| UMRN | |  | | | | | | | | | | Medicare Care Card | | | | | | | | | | | | #: | | | |
| Ref: | | | Exp: |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Suburb/Town | |  | | | | | | | | | | | | | | Post Code | | | | | | |  | | | | |
| Phone - Home | |  | | | | | | | | Mobile | | | | | | |  | | | | | | | | | | |
| Care status | | Inpatient | | | | | | | | | | | | Outpatient | | | | | | | | | Not in Care | | | | |
| Interpreter? | | Yes, Language: | | | | | | | | | | | |  | | | | | | | | | Hearing/Speech Difficulty | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Scenario:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cancer Diagnosis | | | |  | | | | | | | | | | | | | | | Diagnosis Date | | | | | |  | | |
| Treatment Team | | | | Hospital | | | |  | | | | | | | | | | | Consultant | | | | | |  | | |
| Treatment | | | | Intent | | | | Curative | | | | | | | | | | | Palliative | | | | | | Unsure | | |
| Treatment | | | | Surgery | | | | | | | | | | | Surgery Date: | | | | | |  | | |
|  | | | | Chemotherapy | | | | | | | | | | | Radiation | | | | | | Other | | |
| Other Health | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for referral:** | | | | |  | | | | | | | | **Person agreed to referral** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health History:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Risk:** | Suicidal Ideation | | | | | | | | Aggression | | | | | | | | | | | Alcohol/Drug | | | | | | | |
| **Psychosocial Scenario:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marital/family problems | | | | | | | Lives alone | | | | | | | | | | | | | | Limited social support | | | | | | |
| Dependent children under 21yrs | | | | | | | | | | | | | | | Age of Children | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrer Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referrer Name | | |  | | | | | | | | | | | | | | | Position | | | |  | | | | | |
| Referrer Service | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone | | |  | | | | | | | | | | | | | | | Date | | | |  | | | | | |

**Please check the following before submitting referral to WAPOS:**

1. Patient consents to referral
2. Adult (18+ years)
3. Diagnosed or treated for cancer in the last 3 years (excluding breast cancer). People affected by breast cancer should contact a member of their treating team to discuss alternative clinical psychology services.
4. Experiencing **cancer related** *clinically significant* psychosocial distress.
5. Current Medicare or Department of Veteran Affairs eligibility

**Please contact the Duty Officer on 08 6457 1177 for further discussion around the appropriateness of the referral and/or service option alternatives.**