E-Referral Form

breast cancer care wa | 20 years strong

Does the client consent to information being passed on and stored by Breast Cancer Care WA? ☐ Yes

CLIENT CONTACT DETAILS

First Name/s	Surname	DOB

Street Address	Suburb	Post Code

	OK to call/leave message		
	Yes	No	
Home Phone	☐	☐	
Mobile	☐	☐	Text preferred ☐
Email	☐	☐	

Ethnicity ☐ ATSI Aboriginal & Torres Strait Islander

Other ie. CALD. Please specify

MEDICAL INFORMATION

Cancer Diagnosis ☐ Early ☐ Metastatic **Date Diagnosed**

Staging ☐ CT ☐ Bone Scan

Current or Planned Treatment

Treating Hospital / Team

PATHOLOGY

Type of breast cancer eg. DCIS, IDC

Grade	Size	Lymph nodes	ER/PR	Her2	LVI

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PSYCHOSOCIAL CARE REFERRAL CHECKLIST (Cancer Australia 2008)

- ☐ Younger than 55 years
- ☐ Children younger than 21 years
- ☐ Issues related to drugs or alcohol
- ☐ Single/separated/divorced/widowed
- ☐ Lives alone/marital/family issues/lack of social support
- ☐ Financial concerns or issues
- ☐ History of stressful life events
- ☐ Increased burden of disease
- ☐ **Previous episodes of depression/mental health issues.** Please specify

Distress Score 0 = no distress to 10 = extreme distress

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

REFERRALS MADE

- ☐ Social Worker/Welfare Officer
- ☐ Clinical Psychologist
- ☐ Physiotherapist

Other Please specify

KEY ISSUES IDENTIFIED

1.

2.

3.

4.

REFERRED BY

Name	**Agency**
Position	**Phone**
Mobile	**Fax**

Click here to **SUBMIT FORM**

Or email as a PDF attachment to:
triage@breastcancer.org.au