E-Referral Form

breast cancer care wa

Does the client consent to information being passed on and stored by BCCWA ☐ Yes

CLIENT CONTACT DETAILS

Date of Referral:

First Name/s	Surname	DOB

Street Address	Suburb	Post Code

Home Phone	Mobile	Email

Ethnicity	ATSI Aboriginal & Torres Strait Islander	Other ie. CALD. Please specify

COVID Vaccination Status	1st	2nd	3rd	Unvaccinated

NEXT OF KIN

Name	Contact No	Relationship

MEDICAL INFORMATION

Cancer Diagnosis	☐ Early	☐ Metastatic	Date Diagnosed
Staging	☐ CT	☐ Bone Scan	

Current or Planned Treatment

Treating Hospital / Team

GP Details

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/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

OTHER REFERRALS MADE

- [ ] Hospital/Social Worker/Welfare Officer
- [ ] Clinical Psychologist
- [ ] Physiotherapist

Other Please specify

KEY ISSUES IDENTIFIED

1.

2.

3.

4.

REFERRED BY

Name	**Agency**
Position	**Phone**
Mobile	**Email**

Click here to **SUBMIT FORM**

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