**Please ensure all fields with a \* are completed.**

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| **\*IMPORTANT INFORMATION REQUIRED BEFORE YOU COMPLETE THIS FORM** |
| **\*Has the patient/client consented to be referred and have their details shared with the appropriate support services?** | Yes [ ]  No [ ]  |
| **\*Has the patient consented to the appropriate support services getting in contact by telephone or email?** | Yes [ ]  No [ ]  |
| **CANCER SUPPORT REFERRAL**  |
| **\*This referral is for a:** | Choose an item. | **If applicable, please describe relationship to patient** | Click or tap here to enter text. |
| **\*Name** | Click or tap here to enter text. | **\*Date of Birth** | Click or tap here to enter text. |
| **\*Address (Inc. Postcode)** | Click or tap here to enter text. | **\*Gender** | Choose an item. |
| **\*Preferred contact Number(s)** | Click or tap here to enter text. | **Email Address** | Click or tap here to enter text. |
| **DETAILS OF PATIENT**  |
| **\*Cancer Diagnosis** | Click or tap here to enter text. | **\*Treatment Status** | Choose an item. |
| **\*Hospital Number & NHS Number** | Click or tap here to enter text. | **Hospital Consultant and CNS** | Click or tap here to enter text. |
| **GP and Surgery** | Click or tap here to enter text. | **Has a DS1500 / SR1 Medical form been issued?** | Yes [ ]  No [ ]  |
| **Is the patient aware of DS1500/ SR1 Medical Form** | Yes [ ]  No [ ]  |
| **Date of issue and by whom (if known)**  | Click or tap to enter a date.Click or tap here to enter text. |
| **Has the prognosis been discussed with the patient?** | Yes [ ]  No [ ]  |
| **Has a referral been made to the community nursing or community palliative care team?**  | Yes [ ]  No [ ]  Not Applicable [ ]  |
| **\*REASON FOR REFERRAL** |
| **Information and advice**  |[ ]  **Emotional / psychological support** (where appropriate, please state level of intervention required on the next page) |[ ]  **Carer’s support** |[ ]  **Bereavement support** |[ ]
| **Support groups/ peer support** |[ ]  **Children and young person support** |[ ]  **Age UK Sheffield home visit required** (50+ years old) |[ ]  **Complementary therapy** |[ ]
| **Exercise and activity/Nutrition** |[ ]  **Legal advice** |[ ]  **Welfare Benefit advice** |[ ]  **Other** (please write more detail on the next page) |[ ]
| ***Please fill in the section on the next page and tell us of any additional needs or information relevant to this referral.*** |

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| **Date of referral** | Click or tap to enter a date. | **Name of Referrer** | Click or tap here to enter text. |
| **Job title** | Click or tap here to enter text. | **Phone number and email address** | Click or tap here to enter text. |

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| **Additional needs or Information relevant to referral** |
| Click or tap here to enter text. |

PLEASE EMAIL THIS FORM TO **sth.wpcancercharityreferral@nhs.net**

In accordance with the UK General Data Protection Regulation and the Data Protection Act 2018, Weston Park Cancer Charity is the Data Controller of the personal data that is collected for the purposes of administering the services at Weston Park Cancer Support.

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