**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**](mailto:sth.wpcancercharityreferral@nhs.net)

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