

Community Oncology Patients Nursing Referral Form

PATIENT DETAILS

Surname: _____ Gender: Male Female

First Name: _____ DOB: ___/___/___ Hospital Number : _____

Address: _____

Mobile No: _____ Tel day: _____ Tel evening: _____

CANCER HISTORY

Diagnosis: _____ Date of Diagnosis: ___/___/___

Patient aware of diagnosis: Yes No Aim of Treatment: Curative Palliative

Surgery Details: _____ Radiotherapy Details: _____

Chemotherapy details: _____

FAX REFERRAL INSTRUCTIONS

- Send referrals and all required documentation to the community nurse
- For all referrals phone the community nurse to ensure referral forms are received

Person Referring: _____

Date of referral: ___/___/___

Title: _____

Hospital Number: _____ Extension No: _____ Pager: _____ Fax No: _____

(Contact _____ if you have concerns or queries)

ECOG performance status please tick ✓

0 = Fully active able to carry out all pre disease performance without restriction

1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, light housework, office work

2 = Ambulatory and capable of all self care but unable to carry out any work activities. Up to and about more than 50% of waking hours

3 = Capable of only limited self care, confined to bed or chair for more than 50% of waking hours

4 = Completely disabled, cannot carry out any self care. Totally confined to bed or chair

Reason for referral please tick ✓

Patient Assessment

SC /IM injections

Central Venous Access Device Care and maintenance

Disconnection of Ambulatory Chemotherapy

Subcutaneous syringe driver

Blood sampling

Other, Specify: _____

Care to be delivered as per protocols, see below for date due, frequency & review date.

NB On discharge from the acute setting the treating cancer unit will give the patient, ✓ indicates what has been included if relevant for patient

Patient documentation/ record sheets

Equipment for one dressing /flushing of central line

Prescription for flushing, cleansing solutions & medications

A cytotoxic spillage kit (contents as per local policy)

A cytotoxic sharps bin or a standard sharps bin

INSTRUCTION ON DATE AND FREQUENCY OF INTERVENTION

SUBCUTANEOUS & INTRAMUSCULAR INJECTIONS

Date Due	Time Due	Type Route/Dose	Frequency (indicate by ✓)
			<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 3 Monthly <input type="checkbox"/> Other

CENTRAL VENOUS ACCESS DEVICES CARE AND MAINTENANCE

Date Due	Time Due	Type	Duration (Continue until instructed otherwise)	Frequency (indicate by ✓)
		PICC <input type="checkbox"/> Valved <input type="checkbox"/> Unvalved	ForN/A	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 3 Monthly
		Port-a – cath™ <input type="checkbox"/> Valved <input type="checkbox"/> Unvalved	ForN/A	
		Hickman line™ <input type="checkbox"/>	ForN/A	

DISCONNECTION OF CHEMOTHERAPY

Date due	Time Due

BLOOD SAMPLING

Date due	Time Due
Date due	Time Due

SUBCUTANEOUS SYRINGE DRIVER

Date due	Time Due

ADDITIONAL ASPECTS OF CARE REQUIRED

Date Due	Specify intervention
Review Date at Cancer Treating Unit	