REFERRAL FORM
ADOLESCENT & YOUNG ADULT CANCER SERVICE

Enquiries: (03) 8559-6880. Fax this form to: (03) 8559-6229. Email this form to: referralontrac@petermac.org.

The ONTrac at Peter Mac Victorian Adolescent & Young Adult Cancer Service is a multidisciplinary team providing clinical services, information and support to young people with cancer aged 15-25 years and their family. Services are provided alongside disease specific management. Please complete the form and return by fax or email. A member of our team will then make contact with the young person.

Patient Details: PLEASE PRINT	
Surname:	Birth Date:
First Name/s:	Birth Country:
Title: ☐ Mr ☐ Miss ☐ Ms ☐ Mrs ☐ Dr	Country of Residence:
Street Address:	Sex: ☐ Male ☐ Female ☐ Other
Suburb & Postcode:	Preferred Language:
Contact Phone no:	Interpreter Required: ☐ Yes ☐ No
Email Address:	Medicare No:
Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown / Not Specified	

Next of Kin / Contact Person: PLEASE PRINT		
First Name & Surname:	Relationship to Patient:	
Street Address:	Contact Phone no.:	
Suburb & Postcode:		

Diagnosis and Treatment: PLEASE PRINT	
Cancer Diagnosis Date:	
Cancer Diagnosis:	Primary Site:
Current Status: ☐ First Cancer Diagnosis	☐ Cancer Recurrence
Current Treatment Regimen:	
Is the patient aware of this referral to ONTrac? ☐ Yes ☐ No	
Other relevant referral information:	

Treating Team: PLEASE PRINT	
Treating Doctor Name:	Treating Doctor Phone no.:
Treating Hospital Name:	Treating Hospital Department:

Referrer Details: MUST BE COMPLETE BY MEDICAL CLINICIAN PLEASE PRINT	
Referring Doctor Name:	Practice name & address:
Provider number: Date:	
How long is this referral valid for? ☐ 3 months (*Specialists only*) ☐ 12 months	
Mandatory Signature:	Phone Number: Fax No: