PATIENT REFERRAL FORM

Enquiries – phone 03 8559 6880

Save, print & fax this form to: 8559 6229 or save & email to: referralontrac@petermac.org

ONTrac at Peter Mac
Victorian Adolescent & Young Adult Cancer Service

The ONTrac at Peter Mac Victorian Adolescent & Young Adult Cancer Service provides a clinical service, information and support to young people and their families in addition to a secondary consultation, information and referral service for healthcare professionals. Services are provided alongside the services delivered by the primary treating team.

REQUIRED SERVICE (tick all that apply)

AYA/Paediatric Oncologist:
- ☐ Medical Management
- ☐ Medical Second Opinion
- ☐ Adolescent Health Assessment

☐ AYA Nurse Consultant
☐ Social Work
☐ Psychology
☐ Occupational Therapy

☐ Exercise Physiology
☐ Music Therapy
☐ School/Education Advisor
☐ Vocation/Employment Advisor

☐ Family/Sibling Support
☐ Survivorship Clinic
☐ Genetic Counselling Advice
☐ Clinical Trials Information

Patient Details PLEASE PRINT

Surname:	Birth Date: DD/MM/YYYY
First Name/s:	Birth Country:
Title: ☐ Mr ☐ Miss ☐ Ms ☐ Mrs ☐ Dr	Country of Residence:
Street Address:	Sex: ☐ Male ☐ Female
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:		

Patient Diagnosis and Treatment PLEASE PRINT

Cancer Diagnosis date: DD/MM/YYYY

Cancer Diagnosis: Primary Site:

Current Status: ☐ First Cancer Diagnosis ☐ Cancer recurrence

Current Treatment Regimen:

Clinical Trial Participant: ☐ Yes* ☐ No ☐ Unknown/Not specified *If yes, trial name/acronym:

Treating Team PLEASE PRINT

Treating Doctor Name:	Treating Doctor Phone no.:
Treating Hospital Name:	Treating Hospital Department:

Referral Details PLEASE PRINT

Is the patient aware of this referral to ONTrac? ☐ Yes ☐ No

Does the patient consent to their information being presented at the AYA MDT? ☐ Yes ☐ No

Other relevant Referral information:

Referrer Name:	Referrer Position:
Referrer Phone:	Referrer Email:
Referrer Signature:	Referral Date:

OFFICE USE ONLY APPT DATE: ____ / ____ / _____ URN: _____ Entered by: _____

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