The Christie NHS
NHS Foundation Trust

Please fax to: 0161 446 8103

PSYCHO-ONCOLOGY SERVICE REFERRAL FORM

Patient details (affix label here)

Patient Tel:

Date:

WARD NO __ OUTPATIENT ☐ DAY PATIENT ☐

CONSULTANT: ……

DIAGNOSIS: ……

Referred by …… **Job Title** ……..

Contact Number :…….. **Bleep** ……

URGENT ☐ Bleep (9-5) Routine ☐ Reason if Urgent ……

REASON FOR REFERRAL

- ☐ ***Low Mood***
- ☐ ***Feeling anxious***
- ☐ ***Difficulty adjusting to survivorship***
- ☐ ***Past Psychiatric History***
- ☐ ***Non-compliance***
- ☐ ***Drugs/Alcohol Misuse***
- ☐ ***Behavioural Disturbance***
- ☐ ***Difficulty adjusting to diagnosis/treatment***
- ☐ ***Confusion Assessment***
- ☐ ***Support with Capacity Assessment***
- ☐ ***Suicide Risk Assessment***
- ☐ ***Other***

Please give further details of current presentation:

Any past psychiatric history? ? ☐ Yes ☐ No

Risks: Are you concerned about any of the following?

- ☐ ***Risk to self***
- ☐ ***Self neglect***
- ☐ ***Risk to others***
- ☐ ***Safeguarding issues***

Has patient consented to referral? ☐ Yes ☐ No