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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Consent for Referral:** | | | | | | | | | | | | | | **🞏 Yes** | | | **🞏 No** |
| **Private Health Insurance?:** | | | **🞏 Yes, fund:** | | | | | | | | | | | | | | **🞏 No** |
| **This Referral is made for a Patient of: 🞏 Bendigo Health 🞏 Peter MacCallum Cancer Centre** | | | | | | | | | | | | | | | | | |
| **Bendigo Health UR No:**  (if known) | | | | **Peter Mac UR No:**  (if known) | | | | | | | | **DOB:** | | | | | |
| **Surname:** | | | | | | | **Given Name** | | | | | | | | | | |
| **Address:** | | | | | | | | | **Email:**  **@** | | | | | | | | |
| **Town:** | | | | | | | | | | | **Postcode:** | | | | | | |
| **Telephone:** | | | | | | | **Mobile:** | | | | | | | | | | |
| **Diagnosis:** | | | | | | | | | | | **ECOG:**  **🞏 0 🞏 1 🞏 2 🞏 3 🞏 4** | | | | | | |
| **Reason for Referral: 🞏 Deconditioning 🞏 Fitness 🞏 Rehabilitation**  **🞏 Other: (please advise)** | | | | | | | | | | | | | | | | | |
| **Is an interpreter required for this patient?** | | | | | | | | **🞏 Yes, language:** | | | | | | | | **🞏 No** | |
| **Current Treatment:** | | | | | | | | | | | | | | | | | |
| **🞏 Chemotherapy** | | | **🞏 Radiotherapy** | | | | | | | | **🞏 Surgery** | | | | | | |
| **🞏 Immunotherapy** | | | **🞏 Hormone Therapy** | | | | | | | | **🞏 Treatment Complete** | | | | | | |
| **Medical History:** | | | | | | | | | | | | | | | | | |
| **Current Medications:** | | | | | | | | | | | | | | | | | |
| **Relevant Imaging and Test Results for Review:** | | | | | | | | | | | | | | | | | |
| **🞏 MRI** | **🞏 PET** | | | | **🞏 X-Ray** | | | | | **🞏 CT** | | | | | **🞏 Pathology** | | |
| **🞏 Other: (please advise)** | |  | | | | | | | | | | | | | | | |
| **Medical Clearance for Exercise Participation** | | | | | | | | | | | | | | | | | |
| **Do you give medical clearance for this patient to participate in exercise?** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | **🞏 Yes** | | | | **🞏 No** |
| **Consent Provided by:**  **Date:**  **Signature:** | | | | | | **Full Name and Contact Details:**  (Stamp) | | | | | | | | | | | |