|  |  |  |
| --- | --- | --- |
| **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) |