**Outpatient Referral**

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| **Complementary therapy referrals:** Due to the long waiting list, we can currently only accept new referrals for patients who meet the urgent referral criteria. |

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| MVCC Oncology Consultant: Dr/Prof Hospital no:       MVCC [ ]  NHS patient [ ]  Private patientCounselling and complementary therapy are only available to patients (or their carers) under the care of a MVCC oncologist. Patients who do not meet the eligibility criteria may be able to attend relaxation classes, be offered the Therapy Network list and national programmes, eg, LGFB, HOPE etc. Please check if you are not sure. |

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| **Details** [ ]  Patient [ ]  Carer First name:  Last name: [ ]  Male [ ]  Female Date of birth:      Address:                   Postcode:      Home tel:       Work tel:      Mobile tel:       Can message [ ]  Yes [ ]  No be left?  | **GP details**Name:      Address:                        Postcode:       |

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| **Clinical details**Diagnosis/site of disease:      Current treatment (if any): [ ]  Radiotherapy LA:       Appt time:       Date started:       Date completed:      [ ]  Chemotherapy Date started:       Date completed:      [ ]  Hormone treatment [ ]  Ward:       [ ]  Other:      [ ]  Immunotherapy |

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| **Person completing this referral form**Name (please print):       Position:       Telephone:       Date:       Referred by (if different from above): Name:       Position:       Telephone:        |

**Please turn over to identify which service is required 🢥**

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| [ ]  | **Counselling**Has the patient had counselling at the LJMC before? [ ]  Yes [ ]  No**Over the last week?**  [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10*No distress Extreme distress*Please tick below any issues for which the patient is seeking help: [ ]  anxiety [ ]  depression [ ]  concerns about death [ ]  body image concerns[ ]  uncertainty re future [ ]  poor self-confidence [ ]  panic attacks [ ]  relationship problems[ ]  sleep problems [ ]  fear of treatment [ ]  other:      Has the person referred **consented** to be contacted about counselling? [ ]  Yes [ ]  NoAn **assessment appointment** has been made: Date:       Time:       Therapist:      Has the patient been given the Counselling leaflet (PI46)?: [ ]  Yes [ ]  NoIs the patient interested in **Art Psychotherapy**? [ ]  Individual [ ]  Group |

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| [ ]  | **Complementary therapy**Has the patient had therapies at the LJMC before? [ ]  Yes [ ]  NoWould the patient prefer to attend: [ ]  During their course of treatment *(give dates on p1)**(only available to radiotherapy and/or geographically distant patients)*  [ ]  After their course of treatment ends *(give dates on p1)* [ ]  Prepared to take short notice cancellation *(no guarantee there will be one)*Any preference for a particular therapy? [ ]  Aromatherapy [ ]  Reflexology [ ]  Indian head massage [ ]  Reiki [ ]  No preferenceReason for referral[ ]  Support to undergo/complete treatment[ ]  Support to adjust after treatment endsPlease also tick any of the following which apply: [ ]  anxiety [ ]  depression [ ]  muscle tension [ ]  insomnia [ ]  pain[ ]  fatigue [ ]  headaches [ ]  constipation [ ]  nausea [ ]  hot flushesHas the patient been told about the **Relaxation Classes**? [ ]  Yes [ ]  NoHas the patient been told about the **Ear Acupuncture Service** (if appropriate)? [ ]  Yes [ ]  NoHas the patient been told about **HOPE/Take Control**? [ ]  Yes [ ]  NoHas the patient been given the Complementary Therapy leaflet (PI16)?: [ ]  Yes [ ]  No |

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| **For LJMC staff only: Comments** |
| A **first appointment** has been made: Date:       Time:       Therapist:       |