

Complete & email to: massey.clinic.pn@massey.ac.nz

Ph (06) 350 5180

REFERRAL IS FOR: Name: _____ DOB: _____ NHI: _____ Gender: _____ Address: _____ Postcode: _____ _____ _____ (attach Bradma / ID label if available)	They are: Patient <input type="checkbox"/> OR Family member <input type="checkbox"/> Contact phone numbers: _____ Email: _____
Contact person & relationship if different (if child must give caregiver): _____	

Client (client's caregiver) has consented to referral / being contacted by the Service: <input type="checkbox"/> Yes <input type="checkbox"/> No For child referral, confirm both parents consented to referral: <input type="checkbox"/> Yes If not, please contact service coordinator
Client can be seen: <input type="checkbox"/> Face to face <input type="checkbox"/> Zoom <input type="checkbox"/> Phone Preference: _____
Messages can be left if the client is unavailable: <input type="checkbox"/> On cell <input type="checkbox"/> Landline <input type="checkbox"/> Text <input type="checkbox"/> With family member
Client (client's parent/caregiver) would like a support person present at initial appointment: <input type="checkbox"/> Yes <input type="checkbox"/> No

REFERRAL IS FROM: Name: _____ Title: _____ Date: _____ Contact details (email/ph): _____ Contact details for consultant/GP for future communication (email/ph): _____

Ethnicities (tick all that apply): Māori NZ European Pacific People Asian Other: _____

Patient Stage in Cancer Continuum: Prevention Diagnosis Treatment
 Post Treatment Palliative Care Disease Recurrence

Diagnosis and current situation:	(If family member, please provide patient information)
What would you like Massey Cancer Psychology Service to assist with?	
Other services involved with care or referrals in process?	
Safety/Risks: Are there any current safety issues (risk of harm to self, to others, from others):	
Brief outline of current treatment/medication:	
Prognosis:	
Child Only: Are there any care/custody/protection/access issues?	
Inpatient only: please state ward number & anticipated admission/discharge date: _____	

Priority: Routine Moderate High

If you have indicated **high priority** please phone the Service on 06 350 5180 to discuss response timeframe