**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 patient  Counselling 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  No  An **assessment appointment** has been made: Date:       Time:       Therapist:  Has the patient been given the Counselling leaflet (PI46)?:  Yes  No  Is the patient interested in **Art Psychotherapy**?  Individual  Group |

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|  | **Complementary therapy**  Has the patient had therapies at the LJMC before?  Yes  No  Would 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 preference  Reason for referral  Support to undergo/complete treatment  Support to adjust after treatment ends  Please also tick any of the following which apply:  anxiety  depression  muscle tension  insomnia  pain  fatigue  headaches  constipation  nausea  hot flushes  Has the patient been told about the **Relaxation Classes**?  Yes  No  Has the patient been told about the **Ear Acupuncture Service** (if appropriate)?  Yes  No  Has the patient been told about **HOPE/Take Control**?  Yes  No  Has 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: |