   

## Please accept this referral of the following patient to the Long Term Follow-up Program (LTFP)

Affix UR sticker (if faxing)

Today’s date:

Patients Name: UR Number:

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Date of last treatment: / / Primary Consultant:

Primary Diagnosis: Secondary Diagnosis:

Stage:

If Solid Tumour – Site:

Stage:

If Solid Tumour – Site:

Chemotherapy – Primary Treatment Protocol: Enrolled on study: Y/N Other:

Has the patient been discharged from acute care? Y/N Date of final acute appointment? (Month/Year)

**Yes No Comments**

Surgery:  

Radiation:   Field:

Relapse:   Site:

BMT/Stem Cell Transplant:

 

* Autograft Allogeneic Donor: Conditioning:

**Additional key information:** major complications, other diagnosis, co-morbidities, developmental status, current medications, ongoing therapy. **Please also state all other specialties involved in patient care.**

## Please see this patient in the LTFP in (month/year):

**The LTFP will aim to see patients within 12 months from referral.**

Name (PRINT): Provider Number:

Email:

Signature:

# Referrals will be accepted from any healthcare provider. The LTFP also accepts self-referrals.

**Please return to:** **ltf.program@rch.org.au** **or fax 9345 9165 If you have any queries please call 9345 9152**