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

Today's date: _____/_____/_____

Affix UR sticker (if faxing)

Patients Name:	
UR Number:	
Date of last treatment: _____/_____/_____	
Primary Consultant:	
Primary Diagnosis: **Stage:** **If Solid Tumour – Site:**	**Secondary Diagnosis:** **Stage:** **If Solid Tumour – Site:**
Chemotherapy – Primary Treatment Protocol: **Other:**	**Enrolled on study: Y/N**
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