

Please accept this referral of the following patient to the Long Term Follow-up Program (LTFP) at The Royal Children's Hospital

Today's date: ____/____/____

Patient Details:

Full Name:		
DOB:		
RCH UR Number (if known):		
Gender:		
Address:		
Parent/Carer Full Name:		Mobile number:
Medicare Number:	Ref number:	Expiry date:
Medicare eligible? y/n:		
Indigenous Status:	Aboriginal	Torres Strait Islander
indigenous		Not
Interpreter required? y/n:		Language:

Treatment/Oncology Details:

Primary Diagnosis:		Secondary Diagnosis	
Diagnosis date:		Stage:	
Stage:		If Solid Tumour – Site:	
If Solid Tumour – Site:			
Chemotherapy – Primary Treatment Protocol:			
Other:			
Has the patient been discharged from acute care? y/n		Date finished treatment:	
	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.			

Referring Doctor Details:

Full Name:	
Provider Number:	
Practice Name:	
Practice Address:	
Telephone Number:	
Doctors signature:	Date:

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

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