

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

Today's Date: \_\_/\_\_/\_\_



Parent/Carer full name:			
RCH UR Number (if known):			
Medicare eligible? (Y/N):			
Indigenous Status:			
Interpreter Required? (Y/N):		Language:	
Primary Diagnosis: Diagnosis Date:		Secondary Diagnosis Diagnosis date:	
Stage: If Solid Tumour – Site:		Stage: 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:
<b>Additional key information:</b> major complications, other diagnosis, co-morbidities, developmental status, current medications, ongoing therapy. <b>Please also state all other specialties involved in patient care.</b>			

Referring Doctor Details:

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

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

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

Please return to: [ltf.program@rch.org.au](mailto:ltf.program@rch.org.au) or fax 9345 9165. If you have any queries please call 9345 9152