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www.breastcancersupportivecare.com

Breast Cancer Supportive Care Referral Form

Date: _____

Patient Label

Referring Physician or Care Provider: _____

PRAC ID: _____

Clinic: _____ Clinic Phone # _____

Patient Status:

☐ **Recently Diagnosed – No treatment yet**. (In need of breast cancer information, treatment guidelines, assistance with decisions based on treatment guidelines, coping strategies)

☐ **Undergoing Treatment (Surgery/Chemo/Radiation)** (In need of medical care and coaching during treatment including management of side effects such as fatigue, hot flashes, vaginal dryness, lymphedema, body image, impact on family & coping, etc.)

☐ **Post Treatment (Possibly Herceptin/Hormonal Therapy/Breast Reconstruction)** (Counseling for fear of recurrence, anxiety, depression, rehabilitation and coordination of return to work, managing side effects of treatment, ongoing breast cancer follow-up & surveillance)

☐ **Recurrence/Progression to Metastatic Disease** (Support for patients and family members, navigation of ongoing multidimensional challenges)

☐ **High Risk (Breast/Ovarian Cancer)** (Diagnosed with genetic mutation BRCA1 or BRCA2, Lynch Syndrome, Cowden Disease etc., or strong family history)

Issues or Concerns:

_____

_____

_____

_____

URGENCY of Referral: ☐ Urgent – See within one week

☐ Semi-Urgent – See within a month

☐ Non-Urgent – See within two to three months