

Patient Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ UR No. : \_\_\_\_\_  
(dd / mm / yyyy)

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Contact Method for Follow-Up:

Phone number(s): \_\_\_\_\_

Email address: \_\_\_\_\_

Referring Hospital: \_\_\_\_\_

Referring / Treating Dr: \_\_\_\_\_

Local medical officer: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Current treatment protocol: \_\_\_\_\_

Pt is **enrolled** on a **clinical trial** (record name of the trial): \_\_\_\_\_

Pt is **eligible, but NOT enrolled** (record name of the trial): \_\_\_\_\_

Pt is **eligible** for a clinical trial **but declined** (record name of the trial): \_\_\_\_\_

Pt is **not eligible** for a clinical trial

Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Give your fax number so the referral can be acknowledged*

( ) \_\_\_\_\_

**Person making referral:**

Print Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Indicate which consultant service is required (✓)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Full Assessment   | <input type="checkbox"/> Adolescent & Young Adult Psychologist       | <input type="checkbox"/> Music Therapy               |
| <input type="checkbox"/> Education Advisor | <input type="checkbox"/> Research Officer (re clinical trials)       | <input type="checkbox"/> Epidemiology only           |
| <input type="checkbox"/> Social Worker     | <input type="checkbox"/> Specialist AYA Palliative Care/Pain Control | <input type="checkbox"/> Paediatric/Adult Oncologist |

Brief description of reason for referral:

\_\_\_\_\_

\_\_\_\_\_

Referral received by: \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name

Date

**To contact onTrac@PeterMac:**

Email to: [onTrac@petermac.org](mailto:onTrac@petermac.org)

Phone: (03) 9656 1744

Fax: (03) 9656 1192

Web site: [www.petermac.org/ontrac](http://www.petermac.org/ontrac)