Disability Solutions West Midlands

Cancer Connect
by Disability Solutions West Midlands
cancer care that reflects us

Referral Form

CONFIDENTIAL

About the person being referred

Title

Full name

Date of birth (DD/MM/YYYY)

Gender *tick one*

- [ ] Male
- [ ] Female
- [ ] Other

Address

Postcode

Contact number

Alternative contact

Where appropriate, e.g. a carer or legal representative

Name

Contact number

Relationship of alternative contact to the person being referred

Personal details

National Insurance number

Ethnicity

Preferred language

Cancer & health details

Please complete on the person's behalf if you're referring as their carer or representative

Primary disability

Cancer type

Diagnosis date

Name of cancer centre receiving care

Cancer pathway *tick all that apply*

- [ ] At diagnosis — screening/diagnostic tests completed
- [ ] In treatment — surgery, chemotherapy or radiotherapy
- [ ] In follow up care — managing side effects, monitoring recovery
- [ ] Palliative — holistic supportive care, living with cancer
- [ ] Surviving & thriving — cancer in remission
- [ ] Recurrence — cancer returning post treatment
- [ ] Secondary cancer — metastatic / stage 4
- [ ] SR1 — not surviving beyond 12 months
- [ ] Other — is the person aware of their diagnosis and prognosis?

Additional disability / health conditions

Reason for referral and support required

e.g. connecting to local services and specialist groups for emotional and practical support

Safeguarding

e.g. is the person unable to leave the home, living in a care home, or are there known risks?

Referrer details

Referrer's name

Contact details

Referrer's organisation

Date of referral

Consent

Does the person named above give verbal consent for a referral to be made to the Cancer Connect Project, and to share appropriate medical information with the service and relevant third parties for the purpose of enabling support?

☐ **Yes** ☐ **No** *tick one*

This communication is confidential.

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