

MRN _____
Name _____
DOB _____
Tel: (home) _____ (cell) _____

Referral to Cancer Rehabilitation and Survivorship

Eligibility Requirements:

- Patient must be **seen by oncologist for cancer treatment at Princess Margaret Cancer Centre**
- Reason for referral ***must*** be **cancer related impairment**

Date of Referral: _____	Requires Interpreter: Language: _____
Cancer Diagnosis: _____	Staff Physician/NP Name: _____
Advanced non-curative cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes	Staff Physician/NP Signature: _____
Bony Lesions: <input type="checkbox"/> No <input type="checkbox"/> Yes	<u>OHIP Billing Number:</u> _____
Location(if yes): _____	Form Completed by (if different then above): _____
Precautions for Exercise, Other Considerations: _____	

Reason for Referral (please check all cancer related impairments below)

<p style="text-align: center;">Physical</p> <p><input type="checkbox"/> Musculoskeletal</p> <p style="margin-left: 20px;"><input type="checkbox"/> ROM</p> <p style="margin-left: 20px;"><input type="checkbox"/> Weakness</p> <p style="margin-left: 20px;"><input type="checkbox"/> Pain</p> <p style="margin-left: 20px;">Location: _____</p> <p><input type="checkbox"/> Neurological</p> <p style="margin-left: 20px;"><input type="checkbox"/> Peripheral Neuropathy</p> <p style="margin-left: 20px;"><input type="checkbox"/> Central Nervous System Impairment</p> <p style="margin-left: 20px;">Location: _____</p> <p><input type="checkbox"/> Deconditioning</p> <p><input type="checkbox"/> Lymphedema</p> <p style="margin-left: 20px;">Location: _____</p> <p style="margin-left: 20px;">Active Cellulitis: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="margin-left: 20px;">Ruled out DVT: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p style="text-align: center;">Functional</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Difficulty with ADLs</p> <p><input type="checkbox"/> Return to Work/School</p> <p><input type="checkbox"/> Sexual Health</p> <hr/> <p style="text-align: center;">Cognitive</p> <p><input type="checkbox"/> Brain Fog (memory, attention, concentration)</p> <hr/> <p style="text-align: center;">Other</p> <p>_____</p> <p>_____</p>
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This referral may include a consultation from Dr. Eugene Chang or Dr. David Langelier (Physiatrists). Patients will also be screened for nutrition and psychosocial issues as part of our comprehensive assessment. All services are provided by a transdisciplinary team (occupational therapy, physiotherapy, social work, massage therapy, kinesiology, dietitian and neuropsychology).