Music Therapy Referral Form

[Please email completed form to sarahrose.black@uhn.ca OR fax to Psychosocial Oncology at 416 946 2047]

Date_________________________ Diagnosis ________________________________

Cancer Site Group__________________ Attending Physician__________________

Referred by ________________________

Patient's preferred method of contact (Phone/email address?)

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Reason(s) for referral: Please Check All that Apply

☐ Patient requests complimentary modality of care
☐ Patient requests music as part of care plan
☐ Family/caregivers of patient request music
☐ Patient experiencing emotional distress
☐ Bereavement support
☐ Patient is having difficulty with other treatment modalities
☐ Patient having difficulty coping (e.g. with treatment)
☐ Additional symptom management support (e.g. pain/nausea)
☐ Patient experienced music therapy previously

Other (please specify):

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Timeline: When would the patient prefer to have sessions?
☐ Within the next two weeks ☐ Within the next month
☐ No preference

Additional Information: Please provide any further relevant details:
Culturally relevant information: (Language spoken?) __________________________
Other: ________________________________