Cancer Care Collaborative

A program of Seton Medical Center Austin

Cancer Care Collaborative (CCC) Referral Form

Phone: 512-324-3395 • Fax: 512-324-3399

Please fax a copy of the patient's insurance card, H&P, medication list, recent labs, pathology, cytology and pap smear results (if applicable) with this form

Patient Information

Name: _____ Date of Birth: _____

Phone Number: _____ E-mail: _____

Cancer Diagnosis Codes (Please include ICD-10 Code): _____

_____

• Check here if above required documents are available in COMPASS.

Reason for Referral to Survivorship (Please check all that apply)	
❑ Treatment summary and survivorship care plan ❑ Transition to/discharge to Survivorship Clinic ❑ Survivorship nurse navigation	Transition to/discharge to Survivorship Clinic ❑ Management of side-effects from treatment ❑ High-risk for recurrence/development of other primary cancer ❑ Others

(Please check all that apply)

Physical

- Musculoskeletal
  - ROM
  - Weakness
  - Pain

  Location: _____
- Neurological
  - Peripheral Neuropathy
  - Central Nervous System Impairment

  Location:
- Deconditioning
- Endocrine
  - Nutrition Support
- Cardiovascular
- Pulmonary

Functional

- Fatigue
- Difficulty with ADLs Return to Work/School
- Sexual Health
- Psychological / Emotional Issues

Cognitive

- Brain Fog (memory, attention, concentration)

Other

_____

_____

_____

Provider Name (Print): _____

Office Name & Phone: _____

Provider Signature (Required): _____

❑ Clinic Office/ Physician ❑ Nurse Navigator ❑ Friends/Family	❑ Internet/ Social Media ❑ Community Organization ❑ Others: _____

Date/Time: _____

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Please tell us how you heard about the Seton Cancer Survivorship Center - Survivorship Clinic: