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
- ☐ Management of side-effects from treatment
- ☐ High-risk for recurrence/development of other primary cancer
- ☐ Others

Symptoms (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):_____Date/Time: _____

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

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