Located in Westside Medical
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Referral Form

Patient Label

Date: _____

Referring Physician/Care Provider: _____

PRAC ID: _____

Clinic Name: _____ Clinic Phone #:_____

- Recently Diagnosed - No treatment yet. (In need of breast cancer information, treatment guidelines, assistance with decisions based on treatment guidelines, coping strategies)
- Undergoing Treatment (Surgery/Chemo/Radiation) (In need of medical care and coaching during treatment including management of side effects such as fatigue, hot flashes, vaginal dryness, lymphedema, body image, impact on family & coping, etc.)
- Post Treatment (Possibly Herceptin/Hormonal Therapy/Breast Reconstruction) (counseling for fear of recurrence, anxiety, depression, rehabilitation and coordination of return to work, managing side effects of treatment, ongoing breast cancer follow-up & surveillance)
- Recurrence/Progression to Metastatic Disease (Support for patients and family members, navigation of ongoing multidimensional changes)
- High Risk (Breast/Ovarian Cancer) (Diagnosed with genetic mutation BRCA1 or BRCA2, Lynch Syndrome, Cowden disease, CHEK2, PALB2 etc, or strong family history)

Issues or Concerns:

_____

_____

_____

_____

Urgency of Referral

- Urgent - See within one week
- Semi-Urgent - See within a month
- Non-Urgent - See within two to three months.