St Vincent's NELUNE Men's Health Centre (MHC)
Referral Form
Kinghorn Cancer Centre

PH: (02) 9359 8008

Suite 1, ground level 370 Victoria St
Darlinghurst NSW 2010

menshealthadmin@svha.orga.au

1. Existing SVHA patients with diagnosis of prostate cancer
2. New patients with probable diagnosis of prostate cancer

St Vincent's NELUNE Men's Health Centre Referral Form

Referrer Details

Referrer Name:	Referral Date:
Practice Name:	**Provider Number**:
Address:	Post code:
Phone Number:	Fax:
Email:	

Patient Details

Full Name:		
DOB:		
Address:		Post Code:
Email address:	Mobile:	
Medicare Number: /	Expiry:	

DIAGNOSIS AND TREATMENT:

REASON FOR REFERRAL:

SERVICE AVAILABLE *(Please check the box)*

☐ **Dietitian** - *Weight/diet management, ADT side effect management*	**Wed - Thu**
☐ **Prostate Cancer Nurse**- *Patient education on cancer and treatment, sexual function, prehab for RARP/RT*	**Mon - Fri**
☐ **Physiotherapist** - *Pelvic floor exercise, individual and group exercise program, incontinence management, prehab for RARP/RT*	**Mon, Tue, Wed, Fri**
☐ **Clinical Psychologist & Social Work –** *Support for cancer related mental health concerns, general emotional support, group therapy, and access to support services*	**Mon, Tue, Thu**

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Patient label (affix here)

Referral Information – Only complete if referring to Clinical Psychology or Social Work

Has patient actively agreed to referral?

☐ Yes ☐ No (Patient must consent, in order to be seen)

MAIN REASON FOR REFERRAL *(Choose all that apply)*

☐ Depression
☐ Anxiety
☐ Sleep
☐ Adjustment to illness
☐ Fear of recurrence
☐ Carer strain
☐ Employment challenges
☐ Other:
☐ Social isolation
☐ Young family/children
☐ Domestic/family violence
☐ Child protection concerns
☐ Elder abuse concerns
☐ Financial hardship
☐ Accommodation concerns

SERVICES REQUESTED *(Choose all that apply)*

☐ Initial assessment with Social Worker
☐ Peer-support group
☐ Brief information about supports available
☐ Individual counselling
☐ Group psychological therapy

REASON FOR REFERRAL:

TUMOUR STREAM:

REFERRAL SOURCE:

Disease point at referral:

Name and discipline of referrer:

MENTAL HEALTH / SOCIAL HISTORY *(If aware)*

Mental health history and current team:

Complex financial / Social situation and current team:

Further information:

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