Healthcare Professional Referral Form

IMPORTANT This form is not continuously monitored and must not be used for urgent or emergency concerns. For severe or rapidly worsening symptoms, contact the oncology team, call 911, or direct the patient to the nearest Emergency Department.

NO COMMITMENT OR CHARGE **Submitting this referral does not commit the patient to any service. No payment will be charged unless the patient first chooses and consents to a service and its applicable fees.**

1. REFERRING PROFESSIONAL

Referrer name *

Professional designation *

Referral date (YYYY-MM-DD) *

Organization / clinic *

Department / program

Telephone *

Extension

Secure fax

Work email

Preferred contact method

- ○ Telephone
- ○ Secure fax
- ○ Secure email

2. PATIENT INFORMATION

Legal first name *

Legal last name *

Preferred name

Date of birth (YYYY-MM-DD) *

BC PHN (if required)

Pronouns (optional)

Primary telephone *

Email

Best time to contact

Address

City

Postal code

May Present Help leave a voicemail?

- ○ Yes
- ○ No
- ○ Limited details only

Preferred language / interpreter needs

Accessibility or communication needs

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3. CANCER AND TREATMENT INFORMATION

Cancer diagnosis and subtype *

Treating cancer centre / clinic

Current treatment situation

- ○ Planning / pre-treatment
- ○ Receiving treatment
- ○ Treatment changing
- ○ Follow-up / other

Treatment / protocol and route (if known)

Treatment start, next treatment or relevant date

Oncology contact / prescriber

4. REASON FOR REFERRAL AND SERVICE REQUESTED

Requested service(s) - select all that apply *

- ☐ New consultation
- ☐ New treatment teaching
- ☐ Change-of-treatment teaching
- ☐ Symptom support
- ☐ Decision support
- ☐ Digital health support
- ☐ Caregiver education and support
- ☐ Skills training / procedure support

Specific reason for referral, questions to address and desired outcomes *

Requested timeframe *

- ○ Priority - contact requested within 3 business days
- ○ Routine - contact requested within 10 calendar days

If the concern cannot safely wait for these timeframes, contact the oncology team or emergency services instead of using this form.

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5. CLINICAL CONSIDERATIONS AND SUPPORTING INFORMATION

Relevant concerns - select all that apply

- ☐ None identified
- ☐ Cognition / capacity
- ☐ Infection precautions
- ☐ Home / environmental concern
- ☐ Falls / mobility
- ☐ Distress / mental health
- ☐ Bleeding risk
- ☐ Other - describe below

Relevant precautions, symptoms, psychosocial considerations or safety information

Documents included - select all that apply

- ☐ Treatment plan / protocol
- ☐ Recent clinical notes
- ☐ No documents attached
- ☐ Medication list
- ☐ Relevant laboratory / imaging information
- ☐ Other

6. PATIENT AWARENESS, CONSENT AND PAYMENT

Is the patient aware that this referral is being made? *

- ○ Yes
- ○ No
- ○ Unable to confirm

Consent to referral and contact *

- ○ Patient consents to the referral and to being contacted by Present Help.
- ○ Authorized representative provided consent - complete details below.
- ○ Consent not confirmed - Present Help must not contact the patient until resolved.

Private-service disclosure confirmed *

The patient or representative was informed that Present Help is an independent private-pay service; this referral does not commit them to any service; no fee will be charged until they consent to the service and applicable fees; and declining will not affect their healthcare.

- ○ Confirmed - no commitment or charge before consent
- ○ Not confirmed - do not contact

Authorized representative name, relationship and basis of authority

Payment arrangement

- ○ Patient / family
- ○ Referring organization
- ○ Other / to be confirmed

7. REFERRER DECLARATION AND SECURE RETURN

I confirm that the information provided is accurate to the best of my knowledge, that the patient or authorized representative has been informed as indicated above, and that this referral is not being used for an urgent or emergency concern.

Referrer typed name * | **Date (YYYY-MM-DD) *** | **Initials ***

SECURE RETURN

This form may contain personal health information. Contact Present Help to confirm the appropriate submission method before sending the completed form:

coach@presenthelp.ca | Telephone: (604) 735-4357 | presenthelp.ca/contact