

Fax to Massey Psychology Clinic (06) 355 7985 Ph (06) 350 5180 Email: massey.clinic.pn@massey.ac.nz

REFERRAL IS FOR: Name: _____ They are: Patient OR Family member
 Contact person & relationship if different (if child must give caregiver): _____
 Contact phone numbers: _____ DOB: _____ NHI: _____
 Address: _____
 _____ Postcode: _____ (attach Bradma / ID label if available)

REFERRAL IS FROM: Name: _____ Title: _____
 Date: _____ Contact details for acknowledgement (email/ph): _____
 Future correspondence to be sent as above? If not, please provide future correspondence details:

Ethnicity: Māori NZ European Pacific People Asian Other: _____

Patient Stage in Cancer Continuum: Prevention Diagnosis Treatment
 Post Treatment Palliative Care Disease Recurrence

Diagnosis and current situation:	(Please continue on another sheet of paper if necessary)	
What would you like Massey Cancer Psychology Service to assist with?		
Other services involved with care or referrals in process?		
Safety: Are there any current safety issues: e.g. suicidal - associated with low mood?		
Brief outline of current treatment including any ongoing medication:		
Prognosis:		
Child Only: Are there any custody / access / care and protection issues? Please describe:		
Inpatient only: please state ward number & anticipated discharge date:		

Client (client's parent/caregiver) has consented to referral / being contacted by the Service: Yes / No

Messages can be left if the client is unavailable (please circle): On answerphone / With family member / Text / None

Client (client's parent/caregiver) would like a support person present at initial appointment: Yes / No

Distress Self-Assessment Screen completed & attached (if not please briefly state reason): Yes / No

Priority: Routine Moderate High

If you have indicated high priority please phone the Service on 06 350 5180 to discuss response timeframe