CLEAR SUBMIT

CANCER PATIENT NAVIGATOR REFERRAL FORM

Patient Label

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For more information about the program, visit healthpei.ca/CancerPatientNavigator

Patient Type:	◯ Screening/Pre-Diagnosis ◯ New Diagnosis ◯ Receiving Treatment ◯ Active Surveillance ◯ Long-Term Remission ◯ Palliative or End-of-Life

◯ PEI Resident ◯ Out-of-Province Resident (Province:_____)

Patient's Name: _____
Last Name First Name Initial

Patient Phone: _____ Date-of-Birth: _____

Patient Email: _____

Family Physician or Nurse Practitioner: _____

Has the patient received a diagnosis: ◯ Yes ◯ No Diagnosis: _____

Is the patient aware this referral is being made? ◯ Yes ◯ No

Is the patient currently hospitalized? ◯ Yes ◯ No Location: _____

Reason for Referral (please check all that apply):

◯ **supportive counseling** for cancer-related distress
◯ **practical support** for issues related to finances, transportation, housing, etc.
◯ **out-of-province treatment** (navigational support for out-of-province medical appointments)
◯ **out-of-province resident** (help coordinating care between provinces)
◯ patient would like to **connect with support programs and services** relevant to their diagnosis
◯ patient would benefit from **additional support navigating the health care system** for cancer care (e.g. no primary care provider; poor health literacy; newcomer to Canada; language barrier; complex condition; has experienced challenges during transitions or barriers to care, etc.)

◯ **other:** _____

_____

Referring Clinician: _____ Phone: (_____) _____