SUPPORT SERVICES
REFERRAL TEMPLATE

Children's Tumour Foundation
CONQUERING NF

PATIENT DETAILS

DATE:

Name: .....

Gender: (Circle) Male Female Other **Age:** .....

Phone: ..... **Email:** .....

Address: .....

Suburb: ..... **State:** ..... **Postcode:** .....

Diagnosis: (Circle) NF1 NF2 Schwannomatosis

Reason/s for Referral: eg. phone or peer support, Health Management Kit, general info etc

.....

.....

PARENT/GUARDIAN DETAILS: (FOR ALL CHILDREN UNDER 18 YEARS)

Name: .....

Relationship to child: .....

Phone: ..... **Email:** .....

REFERRER DETAILS:

Name: .....

Position/Speciality: .....

Hospital/Service: .....

Phone: ..... **Email:** .....

CONSENT:

I consent to my/my child's details being provided to The Children's Tumour Foundation of Australia (CTF) so as I may receive information, education, support and other services relevant to my needs and circumstances. I understand that I can withdraw from the service at any time.

Name: ..... **Signature:** .....

Date: .....