### Referral Date: DD/MM/YYYY

#### ADDITIONAL PATIENT INFORMATION
- **Gender identity:** ____________________
- **Sex assigned at birth:** ____________________
- **He, Him** ☐ **She, Her** ☐ **They, Them** ☐ **Other:** ____________________
- **Allergies:** ________________________________________
- **Insurance coverage/self-pay:** ________________________
- **Language spoken:** ________________________________
- **Interpreter required:** ☐ Yes ☐ No

#### REASON FOR REFERRAL - Indicate reason for referring patient and check all boxes that apply
- **Adjustment to Illness (Diagnosis/Treatment/Survivorship)**
  - ☐ Assistance with navigating illness experience
  - ☐ Fear of illness recurrence
  - ☐ Decision making difficulties
- **Significant Distress**
  - ☐ Suicide/self-harm risk
  - ☐ Aggression or homicidal risk
- **Loss and Grief/Bereavement**
  - ☐ Loss of a healthy body and implications (sexual health and body image)
  - ☐ Death and dying

#### Mental Health Concern
- ☐ Previous mental health diagnosis
- ☐ Current mood related challenges (sadness, anxiety, anger, stress, frustration, panic, etc.)

#### Family Dynamics
- ☐ Family dynamic challenges
- ☐ Relationship issues
- ☐ Communication challenges
- ☐ Assistance with speaking to children about cancer
- ☐ Child welfare matters

#### Functional Aspects/Tasks
- ☐ Financial matters
- ☐ Employment
- ☐ Housing
- ☐ Transportation
- ☐ Access to community supports/resources

### OTHER RELEVANT PATIENT CLINICAL INFORMATION
Please include any other relevant medical history, diagnostic/clinical information:

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