Lymphoma Australia Referral Form

Email completed form to: nurse@lymphoma.org.au • Lymphoma Care Nurses support line: 1800 953 081
Please provide patient or carer information, so that Lymphoma Australia can provide the most appropriate support and information. A Lymphoma Care Nurse will contact the patient/carer within 1-2 business days.

Date of referral	

PATIENT DETAILS

First name		Last name	
DOB		Phone	
Email			

Indigenous status		Aboriginal		Torres Strait Islander		Both		Neither		Not specific/unknown

Street address					
Suburb		State		Postcode	
Treating hospital					

NOMINATED CONTACT/CARER ON PATIENT'S BEHALF (IF APPLICABLE)

First name		Last Name	
Phone		Relationship to patient	

MEDICAL DETAILS

Lymphoma/CLL diagnosis	

	YES	NO		YES	NO
New diagnosis of lymphoma/CLL			Relapsed or refractory lymphoma/CLL		
Post treatment			Living with lymphoma		

CURRENT TREATMENT MANAGEMENT (SELECT ALL THAT APPLIES)

	YES	NO
Not known yet		
Treatment plan		

	YES	NO
Do you wish to receive emails about Lymphoma Australia's upcoming events and eNewsletters?		

HEALTHCARE PROFESSIONAL MAKING REFERRAL

Name		Position	
Phone		Email	

I hereby give consent for my healthcare team to provide personal and sensitive information to Lymphoma Australia. I understand that the personal details provided on this form will be used to ensure that the Lymphoma Australia representative can provide me with the most relevant information. I consent to being contacted via phone, email or post and that I can opt out of this at any time by contacting Lymphoma Australia.

Verbal consent* All components of this form have been discussed with the patient/guardian/resident/representative and they have consented to the sections marked above. Consent was given by:

- Patient on own behalf
- Parent, guardian or carer
- Authorised substitute decision maker for patient

*Referral form would need to be signed by referring health care professional - add to referrer details opposite Health Care Professional tick boxes. Reviewed and revised March 2021.