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# Referral Form for Psychological Assessment

## Teenagers and Young Adults with Cancer

### Patient Details

**Name:**

**D.O.B.:**

**MRN:**

**Address:**

**Contact Telephone/Email:**

### Reason for Referral: (enter details in box below)

### Medical Information

**Please include a copy of the MDT summary if possible**

### Diagnosis:

**Relevant Medical Information: e.g. complications, metastatic disease, prognosis, reaction to diagnosis and/or treatment: (enter details in box below)**

**Consultant:**

**Referred by (Name and Job Title):**

**Email:**

**Telephone:**

**Please sign to confirm the patient has consented to the referral being made**

**Signed:**

**Date:**

**Please return form to:** Dr Emily Betts, Macmillan Clinical Psychologist, TYA Team, Churchill Hospital. Email: [tya.oxford@nhs.net](mailto:tya.oxford@nhs.net) (only secure if sent from another @nhs.net address) Tel: 01865 572281/227403