Integrated Cancer Therapies

Complementary Therapy Referral Form

Name: . . . . D.O.B: . . . .

Address: . . . .

. . . .

Tel. No: Home: . . . . Work: . . . . Mobile: . . . .

Next of Kin: . . . . Contact No.: . . . .

GP: . . . . Consultant: . . . .

In-patient: ☐ Outpatient: ☐

Hospital/Ward: . . . .

Diagnosis: . . . .

Other medical information: . . . .

. . . .

Presenting symptoms:

anxiety/stress/depression	☐	sleep/fatigue	☐	weight/appetite changes	☐
diarrhoea/constipation	☐	nausea/vomiting	☐	pain/discomfort	☐
lymphodema	☐	impaired immunity/healing	☐	needle phobia	☐
hormonal problems	☐	poor body image	☐	skin problems	☐
respiratory problems	☐	support/coping	☐	well-being	☐

Treatment to date:

chemotherapy ☐ radiotherapy ☐ surgery ☐ symptom control ☐

Name of referrer: . . . . **Signature**: . . . .

G.P.	☐	Consultant	☐	Nurse	☐	McMillan	☐	Radiographer	☐	Occ. Therapist	☐
Physio	☐	Self	☐	Carer	☐	Other	☐	(specify)			

Information leaflet received Yes ☐ No ☐

Freephone: 0800 3166772 ***www.integratedcancertherapies.org.uk***