



cancer fund
for children

REFERRAL FORM



We can help...

by offering specialist therapeutic services to children, teenagers or young adults aged 0-24 diagnosed with cancer, and their families.

FOR OFFICE USE ONLY

Diagnosed Child/Teenager/Young Adult

Name: _____

Date Received: ____ / ____ / ____ Ref. number: _____

Section 4: Referrer Information

Title	<input type="text"/>	First name(s)	<input type="text"/>	Surname	<input type="text"/>
Job Title	<input type="text"/>				
Address	<input type="text"/>				
Postcode	<input type="text"/>	Email	<input type="text"/>		
Telephone	<input type="text"/>	Mobile	<input type="text"/>		
Signature	<input type="text"/>			Date	<input type="text"/> / <input type="text"/> / <input type="text"/>

Section 5: Background Information

Section 6: Consent for Referral (Must be completed by parent/carer/young adult)

I confirm that I give consent for this referral to be made on my behalf to Cancer Fund for Children.

Signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
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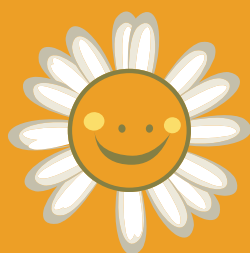
Once you have completed this form please return it to:

The Services Administrator
Cancer Fund for Children,
Curlew Pavilion,
Portside Business Park,
Airport Road West,
Belfast,
BT3 9ED

If you need help completing this form please contact us on:

T: 028 9080 5599

E: services@cancerfundforchildren.com



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NI Charity Commission No. NIC100532

Cancer Fund for Children is registered as a data controller with the Information Commissioner's Office. Our Registration Number is Z1792224. All personal data obtained by Cancer Fund for Children is stored securely in accordance with the principles of the General Data Protection Regulation (GDPR).

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<input type="checkbox"/> New Referral	Signature of Manager	<input type="text"/>
<input type="checkbox"/> Re-referral	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="checkbox"/> Relapse	Allocated to (Specialist)	<input type="text"/>