Cancer Care Kenya

Electronic patient referral form

Surname	Mr/Mrs/Ms
First name	DOB
Postal address	Age
ZIP code	ID No
Physical Address	Occupation
	Next of Kin
Tele:	Tele:

Referring clinician
Telephone number
E mail ID
Address
Date of referral

Brief Medical history

ECOG Performance status 0-1-2-3-4 (*please leave blank if not familiar)*

Signs and symptoms
Provisional diagnosis

Physical examination

Investigations (please fill up the available results)
CBC
RFT
LFT
Others
Urine
X-ray
USG
Mammography
ECG
CT
MRI
Tumor markers
Others if any

Histology

Diagnosis	TNM(*please leave blank if not familiar)*

Co morbidities ,if any:

Current medications

Social and family history

Special needs, if necessary

Clinical diagram (Optional)

Treatment plan (*please leave blank if not familiar)*	
Intent of treatment Curative	Palliative

Place:
Date:

Please mail to: info@cancercarekenya.com.