Alberta Health Services

Affix patient label within this box

# OASIS Referral
## *(Oncology and Sexuality, Intimacy & Survivorship)*
## CancerControl Alberta

Please complete and fax to
- ☐ Edmonton 1.780.432.8291
- ☐ Calgary 1.403.283.6032

For assistance please telephone 1.780.432.8260 (Edmonton) or 1.403.355.3207 (Calgary)

**Referral Source**

☐ Self Referral
☐ Via Health Care Team *(specify)* ______________________________

| Name of Referral Source | Discipline | Phone |
|---|---|---|
| | | |

**Diagnosis and Oncologic Treatment**

______________________________
______________________________
______________________________

**Additional Medical/Surgical/Psychological History** *(Attach relevant Lab work and consults as required)*

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**Reason for Referral** *(check all that apply)*

**Physical**
☐ Pain
☐ Vaginal symptoms
☐ Erectile dysfunction
☐ Bleeding
☐ Bowel and/or Bladder control
☐ Sexual function with appliance *(colostomy, ileal conduit)*
☐ Dry mouth

**Psychological**
☐ Body image
☐ Communication/relationship changes
☐ Anxiety/fear about sexual function
☐ Coping difficulties
☐ Change in desire/libido/arousal

**Education information**
☐ General information
☐ HPV information

**Endocrine**
☐ Reproductive health
☐ Menstruation changes
☐ Menopause symptoms
☐ General hormone changes

**Strength**
☐ Decreased hand function
☐ Fatigue
☐ Decreased endurance

☐ **Other** *(specify)* ______________________________

Patient is aware of referral, and consents to meeting with the OASIS team
☐ Yes ☐ No

| Completed by | Date *(yyyy-Mon-dd)* |
|---|---|
| | |