Patient Intake & Clinical Information Form

Comprehensive Cancer Rehabilitation, Education & Counselling

Thank you for choosing the SEQ Comprehensive Cancer Initiative.

Please complete this form to help us understand your clinical history, current concerns, treatment pathway, consultation goals and support network. This information assists your practitioner in planning personalised, evidence-informed care.

Privacy Notice

This form contains private health information. You may complete it electronically and then print or save it as a PDF, print a blank copy and complete it by hand, or complete it together with your practitioner during your consultation. This PDF does not submit, store or transmit your information. Please keep the completed form secure and provide it only to your practitioner or authorised clinic staff.

About You

Full Name *

Date of Birth *

Phone Number *

Email Address *

Preferred Name (if different)

- [ ] I identify as Aboriginal or Torres Strait Islander

Diagnosis & Treatment History

Primary Cancer Diagnosis / Pathology *

Current treatment stage / protocols (select all that apply)

- [ ] Newly diagnosed / preparing for treatment
- [ ] Platinum-based chemotherapy (for example Cisplatin, Carboplatin or Oxaliplatin)
- [ ] Taxane-based chemotherapy (for example Paclitaxel or Docetaxel)
- [ ] Other chemotherapy regimens
- [ ] Targeted therapy / immunotherapy
- [ ] Actively undergoing radiation therapy (head, neck or skull base)
- [ ] Post-treatment / in remission or surveillance

Additional oncology history (diagnosis date, stage if known, previous treatments and relevant history)

Treatment-Related Physical and Sensory Concerns

Select all that apply

- [ ] New or worsening hearing loss since starting treatment
- [ ] New or changing ringing or buzzing in the ears (tinnitus)
- [ ] Severe communication fatigue or sensory overload
- [ ] Balance difficulties, dizziness or changes in spatial awareness

Please provide any additional detail about these concerns

Your Cancer Care Team

Treating Oncologist *

Treating Surgeon (if applicable)

Managing General Practitioner - GP and practice name *

Treating Hospital / Cancer Centre (if applicable)

Other healthcare professionals involved

Consultation Goals

What are you hoping to achieve through our consultations? Select all that apply.

- [ ] Specialised audiological management for treatment-induced hearing loss or tinnitus
- [ ] Professional counselling to process grief, anxiety and identity changes associated with cancer
- [ ] Clear education about my cancer pathology and recommended treatments
- [ ] Communication strategy training for my partner, children and family support network

Patient Intake & Clinical Information Form

Comprehensive Cancer Rehabilitation, Education & Counselling

Consultation Preferences

Preferred consultation type

- ○ Initial consultation and comprehensive cancer assessment
- ○ Rehabilitative counselling consultation
- ○ Family, carer and child joint consultation

Preferred consultation delivery method

- ○ In-person clinic attendance
- ○ Telehealth consultation - standard hours by video or phone
- ○ After-hours telehealth consultation (7:00 pm to 8:30 pm) due to active treatment fatigue

Anything specific you would like your practitioner to know about your lived experience or current challenges?

Your Circle of Care

Which family members or support-network members are actively affected or participating in care?

- ☐ Spouse / primary partner
- ☐ Children
- ☐ Primary carers or extended family
- ☐ Friends or broader support network

Optional details about family dynamics, communication concerns or support needs

Medicare Referral

Do you currently have a Chronic Disease Management Plan or relevant referral from your GP or cancer care clinician?

- ○ Yes, and I will provide a copy at my consultation
- ○ No, but I plan to discuss referral options with my GP or cancer care clinician
- ○ Unsure - I would like to discuss access pathways during my initial consultation

Documents to Bring or Provide

- [ ] GP referral or Chronic Disease Management Plan
- [ ] Recent audiogram or hearing assessment
- [ ] Relevant oncology letters, treatment summaries or reports
- [ ] Current medication list

Financial Hardship Request

A standard gap fee may apply. Bulk billing or reduced fees may be available at practitioner discretion for patients experiencing financial hardship related to cancer treatment costs.

- [ ] I request consideration for reduced fees or bulk billing where clinically appropriate and available.

Hearing & Communication

Current hearing concerns

Previous hearing assessments, hearing aids, cochlear implants or other hearing supports

Current medications and relevant health information

Anything else you would like your practitioner or clinician to know

Consent & Confirmation

- [ ] I confirm that the information provided in this intake form is accurate to the best of my knowledge.
- [ ] I understand that this form supports consultation planning and clinical care discussions.
- [ ] I understand that this completed form contains private health information and should be stored and shared securely.

Patient / Representative Signature

Signature _____ Date _____

Practitioner / Clinician Notes

Important Information

This form does not replace urgent advice from your treating medical team. For urgent concerns, contact your treating team, attend the nearest Emergency Department or call emergency services on 000.

Please bring or securely provide this completed form to your consultation.