

CABRINI CANCER EXERCISE AND WELLNESS CENTRE



The Cabrini Cancer Exercise and Wellness Centre provides a comprehensive range of multidisciplinary, evidence-based oncology programs and services.

AS YOUR CANCER TEAM, WE STRONGLY RECOMMEND THAT YOU:

- Avoid inactivity and return to normal activities as soon as possible following diagnosis
- Be as physically active as your current condition and ability allows
- Participate in an individually tailored exercise program involving moderate to high intensity:
 - AEROBIC EXERCISE (walking, jogging, cycling, swimming) **and**
 - RESISTANCE EXERCISE (lifting weights)
- Eat a balanced diet that will optimise good nutrition and weight management
- Incorporate strategies based on latest evidence that may help you manage your symptoms and side-effects of treatment
- Ask us for support when you need it most, to improve your overall wellbeing as you manage your cancer diagnosis, treatment and life after cancer

Like to know more?

If you are interested in attending the Cabrini Cancer Exercise and Wellness Centre you can ask your treating healthcare professional to refer you. They can fill in the form overleaf and return it to us. Alternatively you can self-refer and we can contact you to discuss our services and how they may maximise your wellness while dealing with cancer. We are here to guide and support you.

Please note, there are costs associated with the centre's programs and services. Rebates may be available through your private health insurance or ask your GP for a Chronic Disease Management Plan.

REFERRALS: Ph: (03) 9508 1700 Fax: (03) 9508 1455 Email: access@cabrini.com.au



CABRINI CANCER EXERCISE AND WELLNESS CENTRE

REFERRAL FORM – ENROL OR REFER



The Cabrini Cancer Exercise and Wellness Centre provides a comprehensive range of multidisciplinary, evidence-based oncology programs. These programs are goal-orientated and focus on the physical, emotional and social needs of cancer patients and their loved ones. In one location, and overseen by Wellness Co-ordinators, our integrated cancer services offer access to the latest information, peer support, nutritional advice, individually tailored exercise programs, counselling and supportive care needs, to better manage health and wellbeing. Our dedicated and experienced team ensures people with cancer are engaged in their own health behaviours.

For referral queries contact ACCESS Ph: (03) 9508 1700 Fax: (03) 9508 1455 Email: access@cabrini.com.au

For general enquiries contact Wellness Coordinators Ph: (03) 9508 1840 Email: wellnesscoordinator@cabrini.com.au

PATIENT DETAILS

<input type="checkbox"/> Self-referral Register your interest in participating in one of Cabrini's exercise, education and wellness programs to receive a phone call from our Wellness Coordinators.	<input type="checkbox"/> Healthcare referral	
	Has the patient consented to this referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	Title: _____ Surname: _____
		Given name(s): _____
		DOB: _____
		Address: _____
	Alternative contact: _____	Postcode: _____
	Relationship: _____	Email: _____
Phone: _____	Phone: _____	

SERVICE(S) REQUIRED

<input type="checkbox"/> Bladder, bowel and sexual health (pelvic floor physiotherapy)	<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> Diet and nutrition	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Exercise physiology	<input type="checkbox"/> Rehabilitation physician *
<input type="checkbox"/> Health psychology	<input type="checkbox"/> Social work
<input type="checkbox"/> Neuropsychology	<input type="checkbox"/> Speech pathology
<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Other

SPECIFIC PROGRAM (if known)

<input type="checkbox"/> Breast Cancer Rehabilitation Program (ladies only) *
<input type="checkbox"/> Living Well with Secondary Breast Cancer *
<input type="checkbox"/> General Oncology Rehab Program *
<input type="checkbox"/> Lymphoedema program *
<input type="checkbox"/> Maintenance breast group (ladies only)
<input type="checkbox"/> Therapy in the Home
* Programs requiring a medical referral

REASON FOR REFERRAL

Please tick this box if you would like the patient to be reviewed by Wellness Coordinators and referred onto relevant services as identified.

PRIMARY PHYSICIAN

DIAGNOSIS

RELEVANT MEDICAL HISTORY

HEALTHCARE REFERRER DETAILS *

Name: _____	
Profession: _____	Provider number (if relevant): _____
Phone: _____	Fax: _____
Signature: _____	Date: _____