NSW GOVERNMENT Health

THE CROWN PRINCESS MARY CANCER CENTRE, WESTMEAD

REFERRAL PROFORMA

Date of Referral: ___/___/____ ☐ 3 months ☐ 12 months ☐ Indefinite *(except Medical Oncology)*

Referral To Specialty:

☐ Surgery ☐ Medical Oncology ☐ Radiation Oncology ☐ Haematology ☐ Palliative Care

Referral to Dr: _____

Name of Patient: _____

Address: _____

Contact Number: _____ Date of Birth: ___/___/____

Medicare Number: _____ Expiry Date: ___ /___ /____MRN (if known): _____

Cancer Diagnosis:

☐ Breast	☐ Lung	☐ Upper GIT (Liver)
☐ Ovarian	☐ Urology / Prostate	☐ Lower GIT (Colorectal)
☐ Melanoma	☐ Head & Neck	☐ Lymphoma / Leukaemia
☐ Sarcoma	☐ Psych-Oncology	☐ BMT
☐ Neuro	☐ CNS	☐ Dermatology

**** RECENT PATHOLOGY and IMAGING REPORTS and other RELEVANT DOCUMENTATION needs to ACCOMPANY THIS FORM ****

Reason for referral: _____

_____

_____

Referring Dr Name: _____ Contact Number: _____

Signature: _____ Provider Number: _____

This form needs to be completed and returned to CPMCC Westmead Patient Appointments on Fax: 8890 8567 prior to a patient appointment being made.

Enquires contact: 8890 8530 or 8890 5200