ICON CANCER CENTRE HOBART
2 MELVILLE STREET, HOBART TAS 7000
(ENTRANCE OFF CAMPBELL STREET)

ICON CANCER CENTRE

P: **03 6240 2600**
F: **03 5947 5084**
E: **genetics.hobart@icon.team**

Genetic counselling service

Please fax your referral to ***03 5947 5084****. We will contact the patient on receipt of referral.*

This service accepts referrals for patients with a personal and/or family history of breast, ovarian, pancreatic, prostate, bowel or endometrial cancer. If the patient has a cancer not listed here, or has a family history of unusual/rare cancers, a referral to the Tasmanian Clinical Genetics Service may be more appropriate.

PATIENT DETAILS

Full Name:

Gender:

D.O.B:

Phone:

Address:

P/code:

Medicare/DVA Number:

Email:

REASON FOR REFERRAL *(PLEASE SELECT ONE)*

Personal history of cancer (+/- family history of cancer)

* Please include relevant histology
* If panel testing of tumour tissue has been performed please include result/report

Family history of cancer (patient is unaffected)

* Referrals accepted, but be aware that testing is more informative if initiated in an affected family member

Family history of a known hereditary cancer condition (for predictive testing)

Name of mutation positive relative:

Name of hereditary condition or gene:

CLINICAL NOTES

* Please outline current treatment plan (if any) and the reason/s why genetic testing is being considered:

REFERRING DOCTOR/CONSULTANT DETAILS

Doctor Name:

Phone:

Provider No.:

Fax:

Address:

Date:

Signature:

For more information visit us at **iconcancercentre.com.au**