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

ICON CANCER CENTRE

P: 03 6240 2600
F: 03 9086 7990
E: admin.hobart@icon.team

Genetic counselling service

Please fax your referral to **03 9086 7990** *or via* **Argus**.
We will contact the patient on receipt of referral.

PATIENT DETAILS

Full Name: Gender:

D.O.B: Phone:

Address:

P/code:

Health Fund: Health Fund Number:

Medicare/DVA Number:

REASON FOR REFERRAL *(PLEASE SELECT ONE)*

☐ Personal history of cancer (+/- family history of cancer)
* Please attach relevant histology
* If panel testing of tumour tissue has been performed please attach 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)
* Referrals accepted, but be aware that testing is more informative if initiated in an affected family member

Name of mutation positive relative:

Name of hereditary condition or gene:

CLINICAL NOTES

REFERRING DOCTOR/CONSULTANT DETAILS

Doctor Name: Phone:

Provider No.: Fax:

Address: Signature:

Date: