**ICON CANCER CENTRE MIDLAND**
**LEVEL 1, 6 CENTENNIAL PLACE**
**MIDLAND WA 6056**

ICON CANCER CENTRE

P: **08 6317 3400**
F: **08 9250 3287**
E: **admin.midland@icon.team**

# Please fax your referral or upload via HealthLink

HealthLink ID for medical oncologist: **Iconmidm** HealthLink ID for radiation oncologist: **Iconmidr**

*We will contact the patient with the next available appointment*

## PATIENT DETAILS

Full Name: Gender:

D.O.B: Phone:

Address:

P/code:

## REASONS FOR REFERRAL

Condition/Site Group: **Select a condition/site group**

Clinical Notes:

***(PLEASE ALSO INCLUDE ANY PATHOLOGY AND/OR DIAGNOSTIC REPORTS)***

## PREFFERED DOCTOR *(Please indicate if you would like your patient to see a specific doctor.)*

Radiation Oncologist: **Select a Radiation Oncologist**

Haematologist: **Select a Haematologist**

Medical Oncologist: **Select a Medical Oncologist**

## REFERRING DOCTOR/CONSULTANT DETAILS

Doctor Name: Phone:

Provider No.: Fax:

Address: Signature:

Date: