LEVEL 1, CANCER CARE CENTRE
MATER PRIVATE HOSPITAL
30 HEALTH CARE DRIVE
SPRINGFIELD QLD 4300

ICON CANCER CENTRE

P 07 3447 1900
F 07 3144 5651
E admin.springfield@icon.team

Please fax your referral to **07 3144 5651**

We will contact the patient with the next available appointment

PATIENT DETAILS

Full Name: .....

D.O.B: ..... Gender: .....

Address: .....

..... P/code: .....

Phone: ..... Interpreter required: ☐ Yes ☐ No

If yes, language required: .....

REASONS FOR REFERRAL *[PLEASE ENCLOSE ANY PATHOLOGY AND/OR DIAGNOSTIC REPORTS]*

Site Group ☐ Breast ☐ Genitourinary ☐ Lymphoma ☐ Head & Neck ☐ Skin
☐ Lung ☐ Gastrointestinal ☐ Gynaecologic ☐ Endocrine ☐ Palliative

Clinical Notes

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PREFERRED RADIATION ONCOLOGIST

☐ Dr Angela Allen ☐ Dr Marcus Hu ☐ Dr St. John Newman
☐ Dr Manoja Palliyaguru ☐ Dr Edward Sia ☐ Dr Clare Suttie ☐ Next Available

REFERRING DOCTOR/CONSULTANT DETAILS

Doctor Name: ..... Phone: .....

Provider No.: ..... Fax: .....

Address: ..... Signature:

.....

.....

AU ICC 112757 2407