

LIZ PLUMMER CANCER CARE CENTRE
BLOCK E, GROUND FLOOR
CORNER LAKE AND GROVE STREETS
CAIRNS QLD 4870



P: 07 4036 5200
F: 07 4036 5201
E: admin.cairns@icon.team

Please fax your referral to **07 4036 5201** or via **Medical Objects**

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

Site Group:

Clinical Notes:

[PLEASE ALSO INCLUDE ANY PATHOLOGY AND/OR DIAGNOSTIC REPORTS]

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

Radiation Oncologist:

REFERRING DOCTOR/CONSULTANT DETAILS

Doctor Name:

Phone:

Provider No.:

Fax:

Address:

Signature:

Date:

For more information visit us at iconcancercentre.com.au