Epworth | Radiation Oncology

Unit Record Number .....
Surname .....
Given name .....
D.O.B. ..... Age..... Sex.....
Medical Officer .....
Affix Patient Identification Label

EPWORTH RADIATION ONCOLOGY REFERRAL FORM

Please return completed form to:

Richmond

Fax: 03 8420 1950
Email: Radiation.Oncology.Richmond@epworth.org.au

Freemasons

Fax: 03 9483 3332
Email: Radiation.Oncology.Freemasons@epworth.org.au

☐ Inpatient ☐ Outpatient

Location

☐ Epworth Richmond ☐ Epworth Freemasons

Doctor (If a specific doctor is named, patients will be booked on their next available appointment)

Radiation Consultant: - or - ☐ Next available doctor

Patient Details

Surname: ..... First Name: ..... DOB: .....

Address: .....

..... Postcode: .....

Mobile: ..... AH: ..... BH: .....

Sex: ☐ Male ☐ Female

Medicare No.: ..... Ref.: No.: ..... Expiry Date: .....

Reason for Referral: .....

.....

Relevant Past History: .....

.....

* Please attach additional documentation including relevant medical history and investigations (imaging details)

Referring Doctor

Name: ..... Provider No. .....

Address: .....

Email: ..... Phone: ..... Fax: .....

Signature: ..... Date of Referral: .....

For any enquiries, please contact: Richmond: 03 9936 8277
Freemasons: 03 9483 3331

REF2S

05/15

RADIATION ONCOLOGY REFERRAL FORM

REF2S