

Nepean Cancer Care Centre

Cnr Great Western Highway and Somerset Street
Nepean Hospital, Kingswood, NSW 2747
Ph:4734 3500 Fax: 4734 3570

NBMLHD-NepeanCancerCareReferrals@health.nsw.gov.au



Health
Nepean Blue Mountains
Local Health District

Specialists available in this department:

Medical-Oncology	<input type="checkbox"/> Dr Amanda Stevanovic	<input type="checkbox"/> Dr Deme Karikios	<input type="checkbox"/> Dr Jenny Shannon	<input type="checkbox"/> Dr John Park
	<input type="checkbox"/> Dr Pei Ding	<input type="checkbox"/> Dr Dhanusha Sabanathan	<input type="checkbox"/> Dr Anuradha Vasista	<input type="checkbox"/> Dr _____
Radiation Oncology	<input type="checkbox"/> Dr Roland Alvandi	<input type="checkbox"/> Dr Kirsten Van Gysen	<input type="checkbox"/> Dr Vindya Bandara	<input type="checkbox"/> Dr _____
	<input type="checkbox"/> Dr Maria Azzi	<input type="checkbox"/> Dr Ken Tiver	<input type="checkbox"/> Dr Lakmalie Perera	
Palliative Care	<input type="checkbox"/> Dr Alan Oloffs	<input type="checkbox"/> Dr Jeyanthi Kathiresan	<input type="checkbox"/> Dr Mark Dillon	<input type="checkbox"/> Dr Michael Noel
	<input type="checkbox"/> Dr Melinda Van Leeuwen	<input type="checkbox"/> Dr Sam Steele	<input type="checkbox"/> Dr _____	
Psycho-Oncology	<input type="checkbox"/> Dr Cathy Mason	<input type="checkbox"/> Dr _____		
Haematology	<input type="checkbox"/> Dr Anita Shetty	<input type="checkbox"/> Dr John Giannoutsos	<input type="checkbox"/> Dr John Taper	<input type="checkbox"/> Dr John Bishop
	<input type="checkbox"/> Dr Stephen Fuller	<input type="checkbox"/> Dr Yi Ling Tan	<input type="checkbox"/> Dr Man Ho	<input type="checkbox"/> Dr _____
General Clinic	<input type="checkbox"/> Medical Oncology	<input type="checkbox"/> Radiation Oncology	<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Psycho-Oncology
	<input type="checkbox"/> Haematology	<input type="checkbox"/> _____		

Patient Detail:

Name: _____ Date Of Birth: _____
Address: _____
Phone: _____ Previous Surname/s: _____
Medicare No: _____ Parent/Carer Name: _____
Aboriginal/Torres Strait Islander: Yes No Needs Interpreter: Yes No Language: _____

Reason for referral: _____ _____	Urgency: Within : <input type="checkbox"/> 1 Week <input type="checkbox"/> 2 Weeks <input type="checkbox"/> 1 Month _____
Medical History : _____ _____	Significant/Pending Results: _____ _____
Current Medications: _____ _____	Tissue Diagnosis: _____ _____

Referring Doctor's Detail

Name: _____ Provider Number: _____
Practice: _____ Phone : _____ Fax : _____
Date of referral: _____ Signature: _____

Please attach copies of relevant pathology and scanning to this referral