

# Nepean Cancer Care Centre

Cnr Great Western Highway and Somerset Street

Nepean Hospital, Kingswood, NSW 2747

Ph:4734 3500 Fax: 4734 3570



## Health

Nepean Blue Mountains  
Local Health District

**NBMLHD-CancerCareReferrals@health.nsw.gov.au**

Specialists available in this department:

<b>Medical-Oncology</b>	<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 _____
<b>Radiation Oncology</b>	<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	
<b>Palliative Care</b>	<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 _____	
<b>Psycho-Oncology</b>	<input type="checkbox"/> Dr Cathy Mason	<input type="checkbox"/> Dr _____		
<b>Haematology</b>	<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 _____
<b>General Clinic:</b>	<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"/> Dr _____		

**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: \_\_\_\_\_

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

**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**