



Calvary Central Districts Cancer Centre

Calvary Central Districts Hospital – 25-37 Jarvis Road, Elizabeth Vale SA 5112

For all enquiries and appointments phone Adelaide Oncology & Haematology on (08) 8380 1300

Please fax this referral form to (08) 8380 1399 or email to Reception@aoah.com.au or phone (08) 8380 1300 for an appointment

REFERRAL TYPE

- | | | | | | |
|-----------------------|--------------------------|-----------------|--------------------------|--------------------------------|--------------------------|
| Medical Oncology | <input type="checkbox"/> | Genetics Clinic | <input type="checkbox"/> | Respiratory & Sleep Physician | <input type="checkbox"/> |
| Dietitian | <input type="checkbox"/> | Psychology | <input type="checkbox"/> | Lung Cancer Clinic | <input type="checkbox"/> |
| Exercise Physiologist | <input type="checkbox"/> | Rehabilitation | <input type="checkbox"/> | Palliative Care Consultant | <input type="checkbox"/> |
| Radiation Oncologist | <input type="checkbox"/> | Surgeon | <input type="checkbox"/> | Haematology (A/Prof Ian Lewis) | <input type="checkbox"/> |

SELECT PREFERRED MEDICAL ONCOLOGIST (if you do not have a preference, please leave blank and we will arrange appointment with first available)

- | | | | | | |
|-------------------|--------------------------|---------------------|--------------------------|---------------------------|--------------------------|
| Dr Rohit Joshi | <input type="checkbox"/> | Dr Harminder Takhar | <input type="checkbox"/> | Dr Rachel Roberts-Thomson | <input type="checkbox"/> |
| Dr Vy Broadbridge | <input type="checkbox"/> | Dr Kevin Patterson | <input type="checkbox"/> | Dr Vineet Kwatra | <input type="checkbox"/> |

PATIENT DETAILS

Patient surname _____ Birthdate _____
 Given Names _____ Gender _____
 Address _____ Phone _____

REFERRING DOCTOR DETAILS

Doctor's name _____ Address _____
 Provider No _____
 Phone _____ Dr Signature _____
 Fax _____ Date of referral _____

REFERRAL INFORMATION

Symptoms

Past medical history

Relevant imaging (Please attach or fax copy of result if possible)

Type	Date	Imaging Service Provider
------	------	--------------------------