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Referral – Tumour / Oncology

Name / address / d.o.b. of patient	***Name / address / provider no. of referring doctor***

Location of the tumour/s: ______________________________

Symptoms eg lump, unexplained weight loss, night sweats, pain, fracture

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Is the disease suspected to be primary or metastatic? ______________________________

If primary, is there a tissue diagnosis? ______________________________

If metastatic, is the primary known? ______________________________

Has the patient already had treatment? (please circle or delete)

Surgery *Radiotherapy* *Chemotherapy*

If so, who is the oncologist / surgeon?
(with address)

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Please remember to bring any scans, xrays or other documentation regarding your condition when you come to clinic