SHF00223W

MONASH LUNG AND SLEEP
MonashHealth

LUNG ONCOLOGY OUTPATIENT REFERRAL FORM

DATE OF REFERRAL:

PATIENT DETAILS:

GIVEN NAME: **SURNAME:**

D.O.B:

INTERPRETER REQUIRED: Y☐ N☐ **LANGUAGE:**

CONTACT NUMBER: **EMAIL:**

OTHER CONTACT:

REFERRING GP DETAILS:

NAME: **PROVIDER NUMBER:**

PRACTICE ADDRESS:

PHONE: **FAX:**

EMAIL:

REASON FOR REFERRAL (Include current symptoms and their duration)

CT SCAN REPORT ATTACHED **YES:☐** (Referrals will not be triaged without a CT report attached)

RELEVANT PAST MEDICAL HISTORY (Please attach any further relevant documentation)

CURRENT MEDICATIONS

FAX REFERRAL & CT REPORT TO 9594 6311

Concerns for deteriorating patient- contact Respiratory Registrar (via Switch Ph: 9594 6666 or Lung CNC on Ph: 9594 4139)