

Referral

Referral Date: _____

Referral to:	
Name:	Australian Prostate Centre
Address:	Level 8, 14 – 20 Blackwood Street North Melbourne VIC 3051
Phone:	03 8373 7600
Fax:	03 9328 5803
Email:	info@apcr.org.au

Referring Practitioner:	
Name:	_____
Provider Number:	_____
Address:	_____ _____
Phone:	_____
Fax:	_____
Email:	_____

Patient Details:	Address:
Title: _____	_____
Full Name: _____	_____
DOB: _____	Phone: _____
Preferred Name: _____	Mobile: _____
Sex: Male Female Non-Binary	Email: _____
Medicare No: _____ Ref: _____	Pension No: _____
Interpreter Required: Yes No	Preferred Language: _____

Reason for Referral:

Please attach all clinical information, pathology and radiology reports.

Once completed, please fax or email the referral and we will be in contact with the patient with an appointment.

Other Notes: