Australian Prostate Centre

Level 8, 14-20
Blackwood St
North Melbourne
VIC 3051

T 03 8373 7600
F 03 9328 5803
E info@apcr.org.au
australianprostatecentre.org.au

Referral Form

Referral Date: _____

Referral to:

Name: Australian Prostate Centre

Address: Level 8, 14-20 Blackwood Street,
North Melbourne VIC 3051

Tel: 03 8373 7600

Fax: 03 9328 5803

Email: info@apcr.org.au

Healthlink EDI: austproc

Referring Practitioner:

Name: _____

Provider Number: _____

Practice Name: _____

Address: _____

_____

Tel: _____

Fax: _____

Email: _____

Patient Details:

Title: _____ **Address:** _____

First Name: _____ _____

Last Name: _____ **Tel (H):** _____

Date of Birth: _____ **Mobile:** _____

Preferred Name: _____ **Email:** _____

Sex: Male Female Non-Binary **Pension Number:** _____

Medicare Number: _____ **Interpreter Required:** Yes No

Ref: _____ **Expiry Date:** _____ **Preferred Language:** _____

Reason for Referral:

Please attach all clinical information, pathology and radiology reports.

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

Other Notes: