

REFERRAL TO THE ISLHD HEREDITARY CANCER CLINIC

Hereditary Cancer Clinic
Wollongong Hospital
PMB 8808
South Coast Mail Centre NSW 2521

Ph (02) 4222 5706
Fax (02) 4222 5040
Email islhd.iscahn@health.nsw.gov.au

Dear Doctor,

DATE _____

Patient Details

PURPOSE OF REFERRAL *(please check referral guidelines on website)*

Family/personal history of breast cancer

Family/personal history of bowel cancer/multiple bowel polyps

Family/personal history of ovarian or endometrial cancer

Family history of other cancers

Relative has been identified as carrying a genetic fault

Interpreter Required (language): _____

Yours sincerely,

Sign and Print Name _____ **Provider Number** _____ **Date** _____