HARBOUR
CANCER CENTRE

REFERRAL FORM

Harbour Cancer Centre
232 Wairau Road, Glenfield, Auckland 0627
T (09) 925 4444 / F (09) 925 4496
harbourcancercentre.co.nz

Referrer _____ Practice _____

Patient Name:_____NHI#_____

DOB ____ /____ /_____

Phone _____ Mobile _____

Email _____

Type of Cancer: (indicate with an 'X')

Breast ____ Gastrointestinal ____ Genito-urinary ____ Gynaecologica ____ Hepatobiliary ____

Lung ____ Melanoma ____ Skin ____ Brain/CNS ____ Head and Neck ____ Sarcoma ____

Other ____

If possible, please include patients most recent:

Referral letter ____

Radiology reports ____ (Or type of scan, Date and location Preferred) _____

Operation note ____

Pathology reports ____ (Or type of scan, Date and location Preferred) _____

Consultation record ____

Other Investigations ____