

**CANCER SERVICES
NEW PATIENT REGISTRATION FORM**

PATIENT DETAILS				
TITLE	SURNAME	FIRST NAME	MIDDLE NAME	
DOB	SEX (please circle) MALE / FEMALE	COUNTRY OF BIRTH	MARITAL STATUS (please circle) MARRIED / SINGLE / DEFACTO / DIVORCED / WIDOW(ER)	
INDIGENOUS STATUS (please circle) ABORIGINAL TORRES STRAIT ISLANDER ABORIGINAL & TSI NEITHER (OTHER) NONE				
* IS THE PATIENT AWARE OF THE DIAGNOSIS (please circle) YES NO		* CAN THE PATIENT BE CONTACTED WITH APPOINTMENT (please circle) YES NO		
MEDICARE NUMBER	EXPIRY DATE	<input type="checkbox"/> OVERSEAS PATIENT <input type="checkbox"/> PASSPORT & VISA	PENSION NO. / SOCIAL SECURITY STATUS	
VETERANS AFFAIRS NO. COLOUR OF CARD	PRIVATE INSURANCE FUND NAME FUND NUMBER FUND TYPE / LEVEL DO YOU WANT TO USE PRIVATE INS? <input type="checkbox"/> Yes <input type="checkbox"/> No	OCCUPATION *		
STREET ADDRESS		SUBURB / CITY	STATE	POSTCODE
COUNTRY	PHONE NUMBERS WORK HOME MOBILE	INTERPRETER REQUIRED * <input type="checkbox"/> Yes <input type="checkbox"/> No	LANGUAGE (for interpreter)	
EMAIL ADDRESS		NAME OF GP GP ADDRESS		
NEXT OF KIN DETAILS				
NEXT OF KIN (NOK)		RELATIONSHIP	NOK ADDRESS	
SUBURB / CITY	STATE	POSTCODE	COUNTRY	PHONE NUMBERS WORK HOME MOBILE
REFERRAL DETAILS *				
PATIENT REFERRED BY		REFERRING DOCTOR'S ADDRESS EMAIL FAX PHONE		
DIAGNOSIS	REFERRAL LETTER (please circle) FAX MAIL PATIENT TO BRING	CONTACT NAME / PHONE	WARD	
FOR OFFICE USE ONLY *		PERSON TAKING REFERRAL AND DATE		
STAFF SPECIALIST	APPT TIME / DATE	DURATION OF REFERRAL	LIV MRN (from PAS)	ENTERED BY
DATA ENTRY COMPLETE				
<input type="checkbox"/> PASS Registration	<input type="checkbox"/> Financials	<input type="checkbox"/> Referral		
<input type="checkbox"/> Histology	<input type="checkbox"/> Scans	<input type="checkbox"/> Demographics		
<input type="checkbox"/> Docs scanned to Mosaiq	<input type="checkbox"/> Pt / Dr aware of appointment	<input type="checkbox"/> Appointment letter mailed		
Please return with referral letter to:		<u>Liverpool</u>	or	<u>Macarthur</u>
Fax No.		8738 5299		4634 4311
Enquiry Phone No.		8738 5282 & 8738 9821		4634 4300
Liverpool Cancer Services New Patient Request can also be emailed to:-				
SWSLHD-LiverpoolCTCNewPatients@health.nsw.gov.au				
Macarthur Cancer Services New Patient Request can also be emailed to:-				
SWSLHD-MacarthurCTC@health.nsw.gov.au				