

# Referral Form



**Dr Russell Land**

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## Referral Form

### Patient Details:

Name:  Address:   
Home phone number:  Mobile number:   
Date of Birth:

### Please tick Appropriate Service:

- |  |   |
|--|---|
| <input type="checkbox"/> Pelvic Mass/Ovarian Cyst/Elevated Tumour Marker | <input type="checkbox"/> Colposcopy/Abnormal Pap Smear Management                                   |
| <input type="checkbox"/> Gynaecological Oncology (Prophylaxis/treatment) | <input type="checkbox"/> General Gynaecology (Abnormal bleeding/post menopausal bleeding, fibroids) |

### Please Tick:

- If you wish us to contact the patient for an appointment.  
 If you prefer appointment for Pindara Rooms (Gold Coast).

### Comments:

### Referring Doctor:

Name:  Provider Number:   
Address:  Telephone Number:

This Referral has been submitted by:  Dated: