the women's
the royal women's hospital
victoria australia

| PATIENT LABEL | |
|---|---|
| UR: | DOB: |
| First Name: | Sex: |
| Surname: | Gender: |
| Address: | |
| Suburb: | Postcode: |
| Medicare: | Mobile: |

# Fertility Preservation Referral Form – Reproductive Services Unit

## The Royal Women's Hospital

**Non urgent:** Email referrals to referrals@thewomens.org.au or fax (03) 8345 3036

**Urgent (triaged within 24 hours):** Email referrals and queries to rsu.fps@thewomens.org.au

**This referral form is encompassing of Reproductive Services, Public Fertility Care, In Time & NOTTCS**

## Patient Details

| | | |
|---|---|---|
| **Referral urgency:** ☐ Urgent ☐ Routine | | **Previous Women's patient?** ☐ Yes ☐ No |
| **First name:** | | **Last name:** |
| **Sex:** | **Gender**: | **Medicare number:** |
| **Date of birth:** | | **Medicare expiry date:** |
| **Address:** | | **Suburb:** / **Postcode:** |
| **Home phone:** | **Mobile:** | **Email:** |
| **Language:** ☐ English ☐ Other, specify: | | **Interpreter required?** ☐ Yes ☐ No |
| **Aboriginal or Torres Strait Islander?** ☐ Yes ☐ No | | **Disability or special needs?** ☐ No ☐ Yes, specify: |
| **Height (cm):** | **Weight (kg):** | **BMI:** ☐ <35 ☐ >35 |

## Referring Doctor Details

| | | |
|---|---|---|
| **First name:** | | **Last name:** |
| **Provider number:** | | |
| **Referring hospital/clinic:** | | |
| **Practice address:** | | **Suburb:** / **Postcode:** |
| **Phone:** | **Fax:** | **Email:** |
| **Usual GP details** (if not referring doctor): | | |
| **Referring doctor signature:** | | |

## Diagnosis

| **Oncology Diagnosis:** | | | |
|---|---|---|---|
| **Stage Grade:** | | **Node:** | |
| Ca Brain | ☐ | Ca Bladder | ☐ |
| Ca Bowel/Rectum | ☐ | Ca Breast | ☐ |
| ERT PR HER2 ERCA | ☐ | Ca Gynae-cx | ☐ |
| Ca Gynae Endo | ☐ | Ca Gynae Ovarian | ☐ |
| Ca Gynae Uterine | ☐ | Ca Other | ☐ |
| Ca Nasopharyngeal | ☐ | Non-Hodgkin's Lymphoma | ☐ |
| Hodgkin's Lymphoma | ☐ | ALL AML CML | ☐ |
| Leukaemia | ☐ | Multiple Myeloma | ☐ |
| Melanoma | ☐ | Sarcoma Osteo | ☐ |
| Sarcoma Ewings | ☐ | Sarcoma Uterine | ☐ |
| Sarcoma Soft Tissue | ☐ | Tumour Brain | ☐ |
| Sarcoma Other | ☐ | Tumour Other | ☐ |
| Tumour Gyn Ovarian | ☐ | | |

| **Other Diagnosis:** | |
|---|---|
| Aplastic Anaemia | ☐ |
| Autoimmune SLE | ☐ |
| Autoimmune Other | ☐ |
| Stage3/4 Endometriosis with low AMH | ☐ |
| Gender affirming treatment | ☐ |
| Genetic Condition Requiring AHSCT/BMT | ☐ |
| Turner's Syndrome | ☐ |
| Multiple Sclerosis | ☐ |
| Ovarian Cyst | ☐ |
| Renal disease | ☐ |
| | |
| **Other** (please specify): | |

## Treatment history

| Treatment History | | | | | |
|---|---|---|---|---|---|
| **Date of diagnosis:** | | | **Date of last treatment**: | | |
| Previous radiation therapy: | ☐ Yes | ☐ No | Previous chemotherapy: | ☐ Yes | ☐ No |
| Pelvic radiation therapy: | ☐ Yes | ☐ No | with cyclophosphamide?<br>**Regimen**: | ☐ Yes | ☐ No |
| Previous surgery: | ☐ Yes | ☐ No | **Other therapy**: | ☐ Yes | ☐ No |
| Pelvic surgery: | ☐ Yes | ☐ No | Hormone Replacement Therapy | ☐ Yes | ☐ No |
| BMT donor: | ☐ Yes | ☐ No | Gender affirmation treatment: | ☐ Yes | ☐ No |
| BMT autologous: | ☐ Yes | ☐ No | | | |
| **Other treatment/s**: | | | | | |

## Planned treatment for diagnosis

| Planned Treatment for Dx | | | | | |
|---|---|---|---|---|---|
| Chemotherapy | ☐ Yes | ☐ No | Radiation therapy: | ☐ Yes | ☐ No |
| with cyclophosphamide?<br>**Regimen**:<br>**Start date:** | ☐ Yes | ☐ No | Pelvic radiation therapy:<br>**Start date**: | ☐ Yes | ☐ No |
| Hormone / other therapy: | ☐ Yes | ☐ No | Surgery: | ☐ Yes | ☐ No |
| Tamoxifen Herceptin: | ☐ Yes | ☐ No | Pelvic surgery: | ☐ Yes | ☐ No |
| BMT donor: | ☐ Yes | ☐ No | **Other treatment (please specify)**: | | |
| BMT autologous:<br>**Other (please specify):** | ☐ Yes | ☐ No | | | |
| **Comment:** | | | | | |

## Fertility History (if applicable)

| Fertility History | | | |
|---|---|---|---|
| **Age at menarche (years):** | | | |
| Amenorrhea pre-Tx: | ☐ Yes | ☐ No | Comment: |
| Menses resumed post Tx: | ☐ Yes | ☐ No | Comment: |
| **Cycle length:** | | | |
| Previous pregnancies: | ☐ Yes | ☐ No | Comment: |
| TOP: | ☐ Yes | ☐ No | Comment: |
| Previous infertility: | ☐ Yes | ☐ No | Comment: |
| **Duration (years):** | | | |
| **Comment:** | | | |

## Tissue preservation treatment plan (if applicable)

| Tissue preservation treatment plan | | | |
|---|---|---|---|
| Ovarian tissue freeze: | ☐ Yes | ☐ No | Comment: |
| Testicular tissue freeze: | ☐ Yes | ☐ No | Comment: |
| **Comment:** | | | |