**Fertility Preservation Referral Form**

The Royal Women’s Hospital

Locked Bag 300, Level2 Cnr Grattan & Flemington Rds., Parkville 3052

Email: [reproductiveservices@thewomens.org.au](mailto:reproductiveservices@thewomens.org.au)

Fax referral to: 03 8345 3260

Phone: 03 8345 3227

Att. Fertility Preservation – Reproductive Services

Date of referral      /       /

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name  Preferred Name: | Last Name | Previous patient of the Women’s? | Yes  No |
| Date of Birth | Female  Male  Other: | Medicare Number        Healthcare card | Exp. Date |
| Address | | Suburb | Postcode |
|  | |  | |
| Home Phone | Mobile | Email | |
| Aboriginal or Torres Strait Islander? | Yes  No | Interpreter required? | Yes  No |
| Language | Country of birth | BMI? | <35 >35 |
| Disability/special needs? | Yes  No | Specify | |

**Referring/treating doctor/hospital**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring/treating Doctor        Provider number: | | Referring hospital /Clinic: | |
| Phone | Fax | | Email |
| Hospital Address | Suburb | | Postcode |

**Diagnosis**

Relevant Past History

**Planned/current treatment. (Including Location)**

**Date of planned treatment**

**Estimated risk of permanent fertility impairment**

**Investigation Results**

Please attach all relevant investigation results to assist us to triage correctly

|  |  |
| --- | --- |
| Pathology Provider | Radiology Provider |

Tests attached?

|  |  |  |
| --- | --- | --- |
| Blood Tests – recent/relevant | Histopathology | CT/ PET/ Ultrasound/ MRI |

|  |  |
| --- | --- |
| **Doctor’s signature** | **Date** |