**Fertility Preservation Referral Form**

The Royal Women’s Hospital

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

Email: 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** |