**Reproductive Services Referral Form**

The Royal Women’s Hospital

Locked Bag 300, Level 2, Cnr Grattan & Flemington Rds, Parkville 3052  
Phone: 03 8345 3200

Fax referral to: 03 8345 3036

Att.– Reproductive Services

Date of referral      /       /

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | Last Name | Previous patient of the Women’s?  Yes  No |  |
| Date of Birth | Female  Male   Non-binary   Prefer not to disclose | 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 (specify in next box)  No | Specify: |

**Referring/treating doctor/hospital**

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

**Diagnosis**

**Length of time trying to conceive**

**Relevant past history including Gynaelogical and obstetric history**

**Test and investigation results**

Please find below a list of the tests and investigations you need to provide in your referral.   
**IMPORTANT: Results of these tests and investigations must be attached to the referral.**

**Primary patient investigations**

|  |  |
| --- | --- |
| Hepatitis B & C | HIV |
| Cervical screening test (CST) | Rubella |
| Varicella | Syphilis |
| FBE | Blood group and antibodies |
| FSH | LH |
| Prolactin | Ferritin |
| Progesterone (day 21 for regular cycles and adjusted for irregular cycles) | TSH |
| Estradiol (E2) | Free testosterone |
| Sex Hormone Building Globulin (SHBG) | Chlamydia/Gonorrhoea urine or endocervical PCR (if appropriate) |
| Pelvic ultrasound (trans-vaginal if possible) | Karyotype  (Please note: if the patient declines this test, please still send through a referral. Please make a note here to advise the patient has declined this test). |

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

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

**Partner details (If applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | Last Name | Previous patient of the Women’s?  Yes  No |  |
| Date of Birth | Female  Male  Non-binary   Prefer not to disclose | 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 (specify in next box)  No | Specify: |

**Relevant past history including Gynaelogical and obstetric history**

**Partner tests (if patient is accessing our service with a partner).**Please find below a list of the tests and investigations you need to provide in your referral.   
**IMPORTANT: Results of these tests and investigations must be attached to the referral.**

|  |  |
| --- | --- |
| Hepatitis B & C | HIV |
| Karyotype  (Please note: if the partner declines this test, please still send through a referral. Please make a note here to advise the partner has declined this test). | Male hormones (if appropriate) |
| Semen analysis (if appropriate) | Semen antibodies (if appropriate) |

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

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