# 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 84583227

Att. Fertility Preservation – Reproductive Services

Date of referral / /

**Patient details**

| | | | |
|---|---|---|---|
| First Name | Last Name | Previous patient of the Women's? | ☐ Yes ☐ No |
| Date of Birth | ☐ Female ☐ Male | Medicare Number<br>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<br><br>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** |

| | |
|---|---|
| | |