Health
South Eastern Sydney
Local Health District
NSW GOVERNMENT

Facility:

Oncofertility Referral
Fertility and Research Centre

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010429

Key contact numbers

To book **appointments** for males and females (leave message if unattended):	(02) 9382 6633 Opening hours 7.30am – 4pm Mon to Fri
Fax referral form to:	(02) 9382 6638
Andrology clinic emergencies (MALES only):	(02) 9382 6643

Patient Details and Reason for Referral

Patient Medicare number:	Medicare number must be provided	
Private health insurance provider:	Member number:	
Parent name: (<18 yrs only)	Tel:	Date of Referral:
Referred from:	☐ SCH ☐ POWH ☐ RHW ☐ Other:	
☐ Inpatient	Ward:	
☐ Outpatient	Department:	
Name of referring consultant:	Provider No:	
Diagnosis:		
Stage:		☐ Localised or ☐ Metastatic

Current or planned cancer treatment

☐ Chemotherapy:	Start date:	Completed: ☐ Yes ☐ No
☐ Radiotherapy:	Start date:	Completed: ☐ Yes ☐ No
☐ Surgery:	Start date:	Completed: ☐ Yes ☐ No
☐ Other:	Start date:	Completed: ☐ Yes ☐ No

Fertility Treatment Request

Details:

Contraindications to fertility preservation:

Urgency: ☐ < 2day ☐ < 7day or must be before date: / /

Previous fertility treatment undertaken: ☐ No ☐ Yes Date: / /

Blood Tests (required for tissues/gametes being frozen)

Blood test **must** be completed for **all** patients wishing to freeze samples and can be ordered on eMR.

Males and **Females**: Infection screening • rubella (females only)

• HIV • HepBSAg • HepC • VDRL • HTLV 1 & 2 • CMV (IgG and IgM)

Females (for IVF cycle only): • Oestradiol (pmol/L) • AMH (pmol/L) • LH (IU/L) • FSH (IU/L) • Progesterone (nmol/L)

Bloods taken: ☐ Yes ☐ No Date:	Date of LMP:

Referrer Contact Details

Name:		Phone/Pager:	
Position:			
Signature:			

Form developed: Dec 2016 Form review: Dec 2017

Holes Punched as per AS2828.1 2012
BINDING MARGIN - NO WRITING

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