NSW GOVERNMENT Health

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

SMR010525

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
Email referral for to:	SESLHD-fertilityandresearchcentre@health.nsw.gov.au
Andrology clinic emergencies (MALES only):	(02) 9382 6643

Fertility Specialist: ☐ Prof William Ledger ☐ Dr Rachael Rodgers ☐ Dr Rebecca Deans ☐ Dr Louise Fay ☐ Dr Michael Costello ☐ Dr Raewyn Teirney

Patient Details and Reason for Referral

Date of Referral:	Patient Tel:
Parent name: (<18 yrs only)	Parent Tel:
Referred from:	
☐ Inpatient	Ward:
☐ Outpatient	Department:

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

Potential complications for fertility preservation (e.g. Anaesthetic, bleeding risk, immunosuppressed, VTE risk)

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

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

Females:

• Oestradiol (pmol/L) • AMH (pmol/L) • LH (IU/L) • FSH (IU/L) • Progesterone (nmol/L) • beta hCG (IU/L)

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

Referrer Contact Details

Name:		Phone/Pager:	
Position:			
Signature:	Print & Sign		
Name of Referring Consultant		Provider No:	
Contact Details:			

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

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