Fertility Preservation Referral Form – Reproductive Services Unit

The Royal Women's Hospital

Non urgent: From practice software, email: referrals@thewomens.org.au or fax (03) 8345 3036

Urgent (triaged within 24 hours): Email referrals & queries: rsu.fps@thewomens.org.au

Patient Details

Referral urgency: ☐ Urgent ☐ Routine			
First name:		**Last name:**	
Sex:	**Gender**:	**Medicare number:**	
Date of birth:		**Medicare expiry date:**	
Address:		**Suburb:**	**Postcode:**
Home phone:	**Mobile:**	**Email:**	
Language: ☐ English ☐ Other, specify:		**Interpreter required?** ☐ Yes ☐ No	
Aboriginal or Torres Strait Islander? ☐ Yes ☐ No		**Disability or special needs?** ☐ Yes, specify: ☐ No	
Height (cm):	**Weight (kg):**		

Referring Doctor Details

First name:		**Last name:**	
Provider number:			
Referring hospital/clinic:			
Practice address:		**Suburb:**	**Postcode:**
Phone:	**Fax:**	**Email:**	
Usual GP details (if not referring doctor):			

Diagnosis

Oncology Diagnosis:			
Stage Grade:		**Node:**	
Ca Brain	☐	Ca Bladder	☐
Ca Bowel/Rectum	☐	Ca Breast	☐
ERT PR HER2 ERCA	☐	Ca Gynae-cx	☐
Ca Gynae Endo	☐	Ca Gynae Ovarian	☐
Ca Gynae Uterine	☐	Ca Other	☐
Ca Nasopharyngeal	☐	Non-Hodgkin's Lymphoma	☐
Hodgkin's Lymphoma	☐	ALL AML CML	☐
Leukaemia	☐	Multiple Myeloma	☐
Melanoma	☐	Sarcoma Osteo	☐
Sarcoma Ewings	☐	Sarcoma Uterine	☐
Sarcoma Soft Tissue	☐	Tumour Brain	☐
Sarcoma Other	☐	Tumour Other	☐
Tumour Gyn Ovarian	☐		

Other Diagnosis:	
Aplastic Anaemia	☐
Autoimmune SLE	☐
Autoimmune Other	☐
Stage 3/4 Endometriosis with low AMH	☐
Gender affirming treatment	☐
Genetic Condition Requiring AHSCT/BMT	☐
Turner's Syndrome	☐
Multiple Sclerosis	☐
Ovarian Cyst	☐
Renal disease	☐
Other (please specify):	

Treatment history

Date of diagnosis:			**Date of last treatment:**		
Previous radiation therapy: Pelvic radiation therapy:	☐ Yes ☐ Yes	☐ No ☐ No	Previous chemotherapy: with cyclophosphamide? **Regimen**:	☐ Yes ☐ Yes	☐ No ☐ No
Previous surgery: Pelvic surgery: BMT donor: BMT autologous:	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No	**Other therapy**: Surgery: Hormone Replacement Therapy: Gender affirmation treatment:	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No
Other treatment/s:					

Planned treatment for diagnosis

Chemotherapy	☐ **Yes**	☐ **No**	**Radiation therapy:**	☐ **Yes**	☐ **No**
with cyclophosphamide? **Regimen**: **Start date:**	☐ Yes	☐ No	Pelvic radiation therapy: **Start date**:	☐ Yes	☐ No
Hormone / other therapy:	☐ Yes	☐ No	Surgery:	☐ Yes	☐ No
Tamoxifen Herceptin:	☐ Yes	☐ No	Pelvic surgery:	☐ Yes	☐ No
BMT donor:	☐ Yes	☐ No	**Other treatment (please specify)**:		
BMT autologous: **Other (please specify):**	☐ Yes	☐ No			
Comment:					

Fertility History (if applicable)

Age at menarche (years):			
Amenorrhea pre-Tx:	☐ Yes	☐ No	Comment:
Menses resumed post Tx:	☐ Yes	☐ No	Comment:
Cycle length (days):			
Previous pregnancies:	☐ Yes	☐ No	Comment:
Previous abortion:	☐ Yes	☐ No	Comment:
History of infertility:	☐ Yes	☐ No	Comment:
Duration of infertility (months or years):			
Comment:			

Tissue preservation treatment plan (if applicable/known)

Ovarian tissue freeze:	☐ **Yes**	☐ **No**	**Comment:**
Testicular tissue freeze:	☐ Yes	☐ No	Comment:
Comment:			

Other patient history

Other relevant medical or surgical history:
Genetic or family history:
Relevant mental / social health:
Current medications and supplements:
Allergies and reactions:

Investigations

Please attach any relevant investigations or specialist letters

Consent statement

- I have obtained the patient's consent for this referral, its mode of transmission and to share sensitive, personal and health information
- I understand that following triage assessment, this referral may be redirected to a more suitable public health service. *(If your patient does not consent to this, please indicate here: _____)*

Doctor's signature:

Date: Click or tap to enter a date.

General information

- If you do not receive a letter in 2 weeks that your referral has been accepted/declined, please contact the Access Centre (GP use only): (03) 8345 2058, option 2
- Appointment details will be sent to the patient
- It is the referrer's responsibility to continue to monitor the patient's condition and notify us if there is a change that could affect the urgency of treatment, or the care required.
- Encourage your patient to use My Health Record to improve access to pathology/imaging reports and discharge summaries

Useful webpages

- Fertility Preservation Services: https://www.thewomens.org.au/health-professionals/reproductive-services-main/fertility-preservation-service
- Referring to the Women's including tips when sending and how we triage: https://www.thewomens.org.au/health-professionals/for-gps/referrals
- Sign up for Parkville Connect to access your patient's electronic medical record: https://www.thewomens.org.au/health-professionals/for-gps/parkville-connect