

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: <input type="checkbox"/> Urgent <input type="checkbox"/> Routine			
First name:		Last name:	
Sex:	Gender:	Medicare number:	
Date of birth:		Medicare expiry date:	
Address:		Suburb:	Postcode:
Home phone:	Mobile:	Email:	
Language: <input type="checkbox"/> English <input type="checkbox"/> Other, specify:		Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disability or special needs?	
Height (cm):	Weight (kg):	<input type="checkbox"/> Yes, specify:	
		<input type="checkbox"/> No	

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:				Other Diagnosis:	
Stage Grade:		Node:			
Ca Brain	<input type="checkbox"/>	Ca Bladder	<input type="checkbox"/>	Aplastic Anaemia	<input type="checkbox"/>
Ca Bowel/Rectum	<input type="checkbox"/>	Ca Breast	<input type="checkbox"/>	Autoimmune SLE	<input type="checkbox"/>
ERT PR HER2 ERCA	<input type="checkbox"/>	Ca Gynae-cx	<input type="checkbox"/>	Autoimmune Other	<input type="checkbox"/>
Ca Gynae Endo	<input type="checkbox"/>	Ca Gynae Ovarian	<input type="checkbox"/>	Stage 3/4 Endometriosis with low AMH	<input type="checkbox"/>
Ca Gynae Uterine	<input type="checkbox"/>	Ca Other	<input type="checkbox"/>	Gender affirming treatment	<input type="checkbox"/>
Ca Nasopharyngeal	<input type="checkbox"/>	Non-Hodgkin's Lymphoma	<input type="checkbox"/>	Genetic Condition Requiring AHSCT/BMT	<input type="checkbox"/>
Hodgkin's Lymphoma	<input type="checkbox"/>	ALL AML CML	<input type="checkbox"/>	Turner's Syndrome	<input type="checkbox"/>
Leukaemia	<input type="checkbox"/>	Multiple Myeloma	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	Sarcoma Osteo	<input type="checkbox"/>	Ovarian Cyst	<input type="checkbox"/>
Sarcoma Ewings	<input type="checkbox"/>	Sarcoma Uterine	<input type="checkbox"/>	Renal disease	<input type="checkbox"/>
Sarcoma Soft Tissue	<input type="checkbox"/>	Tumour Brain	<input type="checkbox"/>	Other (please specify):	
Sarcoma Other	<input type="checkbox"/>	Tumour Other	<input type="checkbox"/>		
Tumour Gyn Ovarian	<input type="checkbox"/>				

Treatment history

Date of diagnosis:			Date of last treatment:		
Previous radiation therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous chemotherapy with cyclophosphamide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was radiation abdominopelvic / proximal to gonads?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Regimen:		
Previous surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other therapy (specify below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was surgery abdominopelvic / involving gonads?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
BMT donor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hormone Replacement Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMT autologous	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gender affirmation treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other treatment/s:					

Planned treatment for diagnosis

Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy with cyclophosphamide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation (abdominopelvic / proximal to gonads)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy regimen:			Radiation start date:		
Chemotherapy start date:			Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hormone / other therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgery (abdominopelvic / involving gonads)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tamoxifen Herceptin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other treatment (please specify):		
BMT donor	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
BMT autologous	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Comment:					

Fertility History (if applicable)

Age at menarche (years):			
Amenorrhea pre-Tx	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Menses resumed post Tx	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Cycle length (days):			
Previous pregnancies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Previous abortion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
History of infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Duration of infertility (months or years):			
Comment:			

Tissue preservation treatment plan (if applicable/known)

Ovarian tissue freeze	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment:
Testicular tissue freeze	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<p>General information</p> <ul style="list-style-type: none">• 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 <p>Useful webpages</p> <ul style="list-style-type: none">• 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
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