|  |  |
| --- | --- |
| Adolescent and Young Adult  Fertility Preservation Referral | (Affix patient identification label here) |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Assisted Conception Australia -** Ph (07) 3394 4108, Fax (07) 3394 4109  **Queensland Fertility Group (QFG) -** Ph (07) 3015 3079, Fax (07) 3015 3033  **RBWH Fertility Clinic -** Ph (07) 3646 2391, Fax (07) 3646 2307  **Wesley Monash IVF Auchenflower -** Ph (07) 3069 9600, Fax (07) 3217 8379 | |  | | | | *There are costs associated with fertility consults, collection and storage. Please ensure that the patient is aware that some costs may be passed on to them and they should discuss with the fertility specialist.*  *Please see below for a list of fertility groups who have assisted in the past. We do not recommend any one fertility clinic over another. The referrer is free to choose any clinic to refer to.*  **DATE:** Click or tap to enter a date. | | | | | | **PATIENT DETAILS** | | | | | | **Name:** | **Date of birth:** | | **Gender:** | **Age:** | | **Residential address:** | | | | | | **Parent / Guardian name:** | | | | | | **Home phone:**       **Mobile:** | | | | | | **Private health insurance:** | | | | | | **Eligible for QFG/QYCS or Monash/QYCS funding agreement** | | | | | | **REFERRING DOCTOR DETAILS** | | | | | | **Referring Doctor:**       Provider number: | | | | | | **Consultant:**       Provider number: | | | | | | **Ph:**       and ask to page the Dr **Mobile:** | | | | | | **Email:** | | | | | | Queensland Children’s Hospital  Other: | | | | | | **REASON FOR REFERRAL** | | | | | | **Diagnosis:** | | | | | | **Is the referral urgent?**  Yes  No | | | | | | **Copies of current HIV, Hep C, Hep B, Syphilis, serology attached?**  Yes – *must be attached to progress the referral* | | | | | | **PLANNED / CURRENT TREATMENT** | | | | | | **Chemotherapy?**  Yes  No **Tanner Stage:**       **Menses:** | | | | | | **Agents and total dose (mg/m2):** | | | | | | **Estimated first day of treatment:** | | | | | | **Radiation?**  Yes  No | | | | | | **Estimated first day of treatment:** | | | | | | **Planned upcoming surgery?** | | | | | | **Relevant family history:** | | | | | | **Significant past medical history including inherited and metabolic syndromes:** | | | | | | **Referrer signature: D­­­ate:** Click or tap to enter a date. | | | | | | |