**Reproductive Services Referral Form**

The Royal Women’s Hospital

Locked Bag 300, Level 2, Cnr Grattan & Flemington Rds, Parkville 3052
Phone: 03 8345 3200

Fax referral to: 03 8345 3036

Att.– Reproductive Services

Date of referral      /       /

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name       | Last Name       | Previous patient of the Women’s? [ ]  Yes [ ]  No  |  |
| Date of Birth       | [ ]  Female [ ]  Male [ ]  Non-binary [ ]  Prefer not to disclose  | Medicare Number      Healthcare card:       | Exp. Date       |
| Address       | Suburb       | Postcode       |
| Home Phone       | Mobile       | Email       |
| Aboriginal or Torres Strait Islander?[ ]  Yes [ ]  No | Interpreter required?[ ]  Yes [ ]  No  |  Language       | Country of birth       |
| BMI? | [ ]  <35[ ]  >35 | Disability/special needs?[ ]  Yes (specify in next box) [ ]  No  | Specify:       |

**Referring/treating doctor/hospital**

|  |  |
| --- | --- |
| Referring/treating Doctor      Provider number:       | Referring hospital /Clinic:      |
| Phone       | Fax       | Email       |
| Hospital Address       | Suburb       | Postcode       |

**Diagnosis**

 **Length of time trying to conceive**

**Relevant past history including Gynaelogical and obstetric history**

**Is your patient seeking donor egg or donor sperm services? (Please circle Y / N )**

 **Test and investigation results**Please find below a list of the tests and investigations you need to provide in your referral.
**IMPORTANT: Results of these tests and investigations must be attached to the referral.**

 **Primary patient investigations**

|  |  |
| --- | --- |
| [ ]  Hepatitis B & C | [ ]  HIV |
| [ ]  Cervical screening test (CST) | [ ]  Rubella |
| [ ]  Varicella | [ ]  Syphilis |
| [ ]  FBE | [ ]  Blood group and antibodies |
| [ ]  FSH | [ ]  LH |
| [ ]  Prolactin | [ ]  Ferritin |
| [ ]  Progesterone (day 21 for regular cycles and adjusted for irregular cycles) | [ ]  TSH |
| [ ]  Estradiol (E2) | [ ]  Free testosterone |
| [ ]  Sex Hormone Building Globulin (SHBG) | [ ]  Chlamydia/Gonorrhoea urine or endocervical PCR (if appropriate) |
| [ ]  Anti Mullerian Hormone (optional) | [ ]  Pelvic ultrasound (trans-vaginal if possible) |
| [ ]  Karyotype (Please note: if the patient declines this test, please still send through a referral. Please make a note here to advise the patient has declined this test). |

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| Pathology Provider       | Radiology Provider       |

|  |  |
| --- | --- |
| **Doctor’s signature** | **Date** |

**Partner details (If applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name       | Last Name       | Previous patient of the Women’s?[ ]  Yes [ ]  No  |   |
| Date of Birth       | [ ]  Female [ ]  Male[ ]  Non-binary [ ]  Prefer not to disclose  | Medicare Number      Healthcare card  | Exp. Date       |
| Address       | Suburb       | Postcode       |
|        |       |
| Home Phone       | Mobile       | Email       |
| Aboriginal or Torres Strait Islander?[ ]  Yes [ ]  No | Interpreter required?[ ]  Yes [ ]  No  | Language       | Country of birth       |
| BMI? | [ ]  <35[ ]  >35 | Disability/special needs?[ ]  Yes (specify in next box) [ ]  No  | Specify:  |

**Relevant past history including Gynaelogical and obstetric history**

**Partner tests (if patient is accessing our service with a partner).**Please find below a list of the tests and investigations you need to provide in your referral.
**IMPORTANT: Results of these tests and investigations must be attached to the referral.**

|  |  |
| --- | --- |
| [ ]  Hepatitis B & C | [ ]  HIV |
| [ ]  Karyotype (Please note: if the partner declines this test, please still send through a referral. Please make a note here to advise the partner has declined this test). | [ ]  Male hormones (if appropriate) |
| [ ]  Semen analysis (if sperm provider) | [ ]  Semen antibodies (if appropriate) |

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| Pathology Provider       | Radiology Provider       |

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| **Doctor’s signature** | **Date** |