**Urgent referral for Fertility Preservation**

**PATIENT DEMOGRAPHIC DETAILS:**

|  |  |
| --- | --- |
| Patient Name: | DOB: |
| Hospital number: | NHS number: |
| Address: |  |
| Mobile Number: |  |
| Partner’s name (if applicable): |  |

**REFERRER’S DETAILS:**

|  |  |
| --- | --- |
| Consultant: | Hospital: |
| Phone: | Department: |
| **IMPORTANT** Link Nurse Name and their Contact Details: |  |
| Referrer’s signature: | Date: |

**CLINICAL DETAILS:**

|  |  |
| --- | --- |
| **Diagnosis:** |  |
| **How soon must treatment start for patient’s malignancy:**   * **Date if known:** * **< 2weeks** * **2 weeks – 1 month** |  |
| **Type of treatment required:**   * **Chemo (please specify chemo drugs)** * **Radiotherapy** * **Surgery** * **Other (please specify)** |  |
| **Treatment to date for current illness:** |  |
| **Has the patient been informed about their prognosis?**  **What is the 10 year prognosis for the patient?** |  |
| **Are there any contraindications against sedation/ surgery/ general anaesthetic?** |  |
| **Is the patient at increased risk of complications from an invasive procedure? i.e. Egg collection / laparoscopy (bleeding, infection)** |  |
| **Past medical history:** |  |
| **All current Medications:** |  |
| **Height: Weight:**  \*Please note, patients with a BMI >35 may have limited fertility preservation options | **BMI:** |
| **Any other clinical information that we should know about?** |  |

**IMPORTANT: Please send a completed copy of this form to:**

Dr M. Saran / Kelly Monk to:   
  
[**uhs.completefertility@nhs.net**](mailto:uhs.completefertility@nhs.net)

We will confirm the receipt of the referral by email..

**Complete Fertility phone number is 02381205380** in case of any queries.

The patient will be contacted directly to make an appointment, as soon as the referral has been received.

**Referral form is also available on:** Staffnet