Referring Specialist Information Sheet

Female Fertility Preservation Prior to Gonadotoxic Treatment

Steps for Treatment at WFC:

1. Please fill out *Page 1* of the following referral form. Including:

   - ❒ Patient's contact details
   - ❒ Reason for referral
   - ❒ Any current or planned future treatment
   - ❒ Screening Results for HIV, HepB, sAg and HepC Ab together with the Date these tests were done. If results are pending, please provide details of Pathology Laboratory used. NOTE screening for HIV Hep B and Hep C is a mandatory requirement.
   - ❒ Recommended specialists suitable to review and develop a care plan for your patient. A multi-disciplinary team (**MDT**) review is required for all patients.
   - ❒ Your full referral and contact details. NOTE we require you supply a mobile number for urgent discussions

2. Please email the completed Page 1 of this referral form together with screening results to:

   wfc.oncology@sydney.edu.au

3. Once received, the WFC Medical Director will contact you to discuss the treatment options available and details of the MDT composition. The patient will be contacted to arrange an appointment with the Medical Director.

4. If you wish discuss your patient in more detail before submitting this form, please contact Dr Howard Smith via the Westmead Hospital Switch Board on (02) 8890 5555

Westmead Fertility Centre

THE UNIVERSITY OF SYDNEY

Referral for Female Fertility Preservation

Prior to gonadotoxic treatment

PATIENT DETAILS [COMPLETE ALL FIELDS OR AFFIX LABEL HERE]

SURNAME.. MRN..............................

FIRST NAME..D.O.B..........................

ADDRESS..

....

MOBILE:..EMAIL:...

Further Details/ Reason for Referral:

Parent Name (<18 years only) ....Parent Mobile:..

Referred from (hospital): ☐ Westmead ☐ Westmead Children's ☐ Other..

☐ Inpatient Ward: ....

☐ Outpatient Department: ....

Diagnosis: ....

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Stage.. ☐ Localised or ☐ Metastatic

Current or Planned Treatment:

				CIRCLE
NucMed Scan :	....	Start Date:.........................	Completed?	Yes / No
Chemotherapy :	....	Start Date:.........................	Completed?	Yes / No
Radiotherapy:	....	Start Date:.........................	Completed?	Yes / No
Surgery:	....	Start Date:.........................	Completed?	Yes / No

Infectious Screening:
Please note that infectious screening is mandatory for this process. Please include a copy of test results when submitting this form. If results are pending please provide details of the Pathology services used for the testing

DATE
- HIV
- Hep B sAg
- Hep C Ab
- TESTING PATH LAB_______________

Suggested Representation at MDT Composition: ☐ Referring Physician

☐ Fertility Specialist ☐ Anaesthetist ☐ Other..

Referring Treating Specialist Details:

I understand that following this referral, a consultation with multidisciplinary specialists may be required and a care plan developed. I understand that this patient remains under my care while fertility preservation is delivered.

Full Name: ....

Position: .... Provider No.: ....

Email: .... Mobile: ....

Signature: .... Date: ....

PRIOR to the completion of Page 2, please send completed Page 1 of this form to the following for review and approval:
WFC Oncology: wfc.oncology@sydney.edu.au

Patient Surname: DOB:

To be completed by the WFC Medical Director (please used extra pages if needed and take note of attachment)

Multidisciplinary Meeting Outcome - Agreed Care Plan:

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Multidisciplinary Team Member Details:

By signing this form I agree that this care plan is appropriate for the above person.

[MEMBER 1]

Full Name: ……………………………………………………………………………………………

Position: ………………………………………………………………… Provider No.: ……………………

Email: ………………………………………………………………… Mobile: ……………………

Signature: ………………………………………………………………… Date: ……………………

[MEMBER 2]

Full Name: ……………………………………………………………………………………………

Position: ………………………………………………………………… Provider No.: ……………………

Email: ………………………………………………………………… Mobile: ……………………

Signature: ………………………………………………………………… Date: ……………………

[MEMBER 3]

Full Name: ……………………………………………………………………………………………

Position: ………………………………………………………………… Provider No.: ……………………

Email: ………………………………………………………………… Mobile: ……………………

Signature: ………………………………………………………………… Date: ……………………

Once both pages of this form are complete with Dr Smiths signature, please send to the following for upload to WFC Database:

WFC Oncology: wfc.oncology@sydney.edu.au

WFC Med. Dir. Signature: ………………………………………………………………… Date: ……………………