Referral form for Oocyte Vitrification for Adolescents and Young Adults
YF1.2
CAYA (Childhood, Adolescents and Young Adults)

merrion FERTILITY CLINIC

Patient Name	
Date of Birth	
Address	

Patient Guardian/NoK	
Phone number	
Email address	

Referring Physician	
Email address	
Date of Referral	

Cancer Diagnosis		
Stage		
Medical Concerns		
Operative risks		
Recent surgery	Y / N (if 'Y', please attach anaesthetic sheet)	
Possible airway compromise	Y / N	Details
Coagulopathy	Y / N	Details
Abdominopelvic disease	Y / N	Details

Mediastinal disease	Y / N	Details	
Planned treatment			
Chemotherapy	Y / N	Potentially gonadotoxic dose Y / N	Start date
Agents			
Radiotherapy	Y / N	Pelvic/ Non-pelvic	Start date
Surgery	Y / N	Pelvic/ Non-pelvic	Start date
HSCT	Y / N		Start date
Other therapy (e.g., hormonal, immunotherapy, etc)	Y / N		Start date

Social issues of concern	
Accessibility Issues (e.g., Wheelchair)	

I am of the opinion that it is acceptable to defer treatment for up to 3 weeks to allow time for oocyte cryopreservation	Y / N
I have discussed the potential impact of treatment on fertility with the patient and/or parents/guardians	Y / N
I have provided information / link to information leaflet on oocyte cryopreservation	Y / N
Named Consultant (Block capitals):	
Referring Practitioner (Block capitals):	
Signature of Referring Practitioner:	
Date:	