Referral form for Sperm Cryopreservation for Adolescents and Young Adults
YF1.3
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	

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

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

I have discussed the potential impact of treatment on fertility with the patient and parents/guardians	Y / N
I have provided information / link to information leaflet on sperm freezing	Y / N
Parent(s)/Guardian(s) permission to have discussion re: sperm production	Y / N
The concept of sperm production has been explained to the patient	Y / N
Named Consultant (Block capitals):	
Referring Practitioner (Block capitals):	
Signature of Referring Practitioner:	
Date:	