**Survivors of childhood cancer**

Please provide as much relevant information as possible, including medical reports and documentation, to avoid delays.

Name:

Current age:

Date of birth:

Diagnosis:

Age at diagnosis:

Underwent fertility preservation prior to treatment: Yes /No

Site of fertility preservation:

Date of completion of medical treatment:

Date of last cancer treatment:

1. Radiation: Fields / Dose (if possible)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Chemotherapy: Protocol / dose / last dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical documents / Letter to confirm diagnosis and treatment (please add age at treatment)

\*\*\*\* Command for attachments – do not process without \*\*\*\*\*

Is patient currently under surveillance? Yes / No

If Yes, please provide Consultant details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Details:

Please forward letter of fitness regarding suitability for fertility preservation (egg freezing)

Parent / guardian contact details:

Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The concept of fertility preservation and the reason for this referral has been discussed and explained to the patient

Yes / No