|  |  |
| --- | --- |
| **Patient Name** |  |
| **Date of Birth** |  |
| **Height (cm)** |  | **Weight (kg)** |  |
| **Address** |  |
|  |
| **Patient Guardian/NoK** |  |
| **Phone number** |  |
| **Email address** |  |
|  |
| **Referring Physician** |  |
| **Email address** |  |
| **Date of Referral** |  |
|  |
| **Social Issues of Concern** |  |
| **Accessibility issues (e.g., Wheelchair)** |  |
|  |
| **Medical Pathway** |
| **Diagnosis** |  |
| **Medical Concerns** |  |
| **Assessment of impact on future fertility** |  |
| **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 |
|  |
| **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 |

|  |  |
| --- | --- |
| **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:**  |