Referral form for Sperm Cryopreservation for Adolescents and Young Adults

YF1.5 FP AYA (Fertility Preservation, Adolescents and Young Adults)

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

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:	