

Referral for Medically Required Fertility Preservation – Female

FEMALE DETAILS

Forename: _____ Surname: _____
Date of Birth: _____ Health & Care No: _____
Status: Single / Married / Civil Partnership: _____
Contact Numbers - Mobile: _____ Landline: _____
Email: _____

If the patient has a long term partner, they should also attend the appointment.

Clinical reason for referral:

(We do not accept referrals for social reasons)

Where possible please provide details as below

Age & Parity

Likelihood of infertility

Date of commencement of Treatment / Surgery: / /

Referrer's Name:

Designation / Specialty / Dept:

Contact No: _____ Email: _____
(please ensure you provide a reliable number so the RFC Dr can contact you promptly if more information is needed prior to arranging an appointment)

Date of referral: _____ Signed: _____