Belfast Health and Social Care Trust
caring supporting improving together

Regional Fertility Centre

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.
Please provide Partner details (if applicable)

Partner Name:
Date of Birth:
Address:
Email:
Contact Numbers: Mobile Landline:

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: