Hull & East Riding FERTILITY

FERTILITY PRESERVATION REFERRAL FORM

Please email, marked as "urgent" with reference "Fertility Preservation" to:

enquiries@hullfertility.co.uk /contact number (if urgent): 01482 689040

Date: _ _/_ _/_ _

Patient ID

Referring consultant	
Department	
Contact number	
Patient contact number	
Partner/Next of kin/Responsible adult name	
Partner/Next of kin/Responsible adult name contact number	

Diagnosis	
Planned gonadotoxic therapy/ surgery	
Treatment start date	
Any prior gonadotoxic treatment received	
Significant medical co-morbidities/disabilities if any	
Hospital transport required	Yes / No
Reason for referral (Tick appropriate)	Fertility discussion with respect to 1) Egg storage ☐ 2) Sperm storage ☐ 3) Embryo storage ☐

Blood tests required prior to gamete/embryo storage (please attach copies of results)

TEST	DATE TAKEN	RESULT
HIV Antibody 1& 2		
Hep B surface Antigen		
Hep B core Antibody		
Hep C Antibody		
OFFICE USE ONLY:	DATE:	INITIALS:
Referral received and actioned		
Outpatient appointment set up		