RSU FPS PATIENT REFERRAL

Please circle selection or complete details as appropriate

the women's
the royal women's hospital

RSU FPS PATIENT NOTES

BRADMA LABEL or

UR: ..... DOB ...../...../.....
First name: .....
Surname: .....
Street: .....
Suburb/town: ..... Postcode: .....
Mobile: .....

FPS

DIAGNOSIS (Oncology)

Stage Grade Node
Ca_bladder
Ca_bowel/rectum
Ca_breast ER PR HER2 BRCA
Ca_gyn_cx
Ca_gyn_endo
Ca_gyn_ovarian
Ca_gyn_uterine
Ca_nasopharyngeal
Ca_other SPECIFY
Hodgkin's Lymphoma
Non Hodgkin's Lymphoma
Leukaemia ALL AML CML
Melanoma
Multiple Myeloma
Sarcoma_Ewings
Sarcoma_osteo
Sarcoma_soft tissue
Sarcoma_uterine
Sarcoma_other SPECIFY
Tumour_brain
Tumour_gyn_ovarian
Tumour_gyn
Tumour_nongyn

DIAGNOSIS (Other)

Autoimmune_SLE
Autoimmune_other
Donor_ Turner's _other
Endometriosis
Galactosemia
IVF_ No sperm@OPU
Multiple Sclerosis
Ovarian cyst
Renal disease
Social
Wegener's Granulomatosis
Other SPECIFY

Treatment HISTORY

Date of diagnosis / /
Date of last treatment / /
Previous radiation therapy? YES / NO
pelvic / non pelvic
Previous chemo therapy? YES / NO
with cyclophosphamide? YES / NO
Regimen .....
Previous surgery ? YES / NO
pelvic / non pelvic
BMT donor BMT autologous
Other therapy ? YES / NO
Tamoxifen Zoladex cetrorelix OCP
Other .....

PLANNED Treatment for Dx

Chemo therapy ? YES / NO
with cyclophosphamide YES / NO
Regimen .....
Start date / /
Radiation therapy ? YES / NO
pelvic / non pelvic
Start date / /
Hormone/other therapy ? YES / NO
Tamoxifen Herceptin .....
Surgery ? YES / NO
pelvic / non pelvic
BMT donor BMT autologous
Other .....

Fertility HISTORY

Age at menache (yrs) .....
Amenorrhea pre Tx ? YES / NO
Menses resumed post Tx ? YES / NO
Cycle length:
<26 26-35 36-50 >50 days
LMP / /
Previous pregnancies G .....P.....
TOP ..... SAB ..... ECT .....
Previous infertility YES / NO
Duration (yrs) .....
Conception planned:
ASAP Yes No Uncertain

FPS Treatment PLAN

Tissue freeze
Mature oocyte freeze
Embryo freeze
Hormone Tx
Zoladex cetrorelix OCP
..... SPECIFY .....
Start date / /
NO FPS
Confirmed with patient ? YES / NO
Confirmed with oncologist YES / NO

Comments:

Referring specialist .....
Provider Number .....
Clinic .....
Consultation date / /

Email: lab.supervisors@mivf.com.au debra.gook@mivf.com.au
Enquires lab supervisor : 8345 3232

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