repromed
Fertility Specialists.

If you would like to discuss a patient before referring, please contact our Patient Coordinators, SA on 08 8333 8111 or NT on 08 8945 4211

Referring Doctor Name _____

Email Address _____

Provider Number _____ Date of Referral ____/____/_____

Dear Repromed/Dr. _____

Thank you for seeing:

Patient Name _____ Date of Referral ____/____/_____

Partner Name _____ Date of Birth ____/____/_____
(where applicable)

Patient Address _____

_____

Patient Phone Number _____ Patient Email _____

Clinic referring to (please tick)

Repromed Adelaide ☐ Repromed Darwin ☐ Repromed Mildura ☐

Referral for (please tick)

Fertility Assessment ☐	Surrogacy ☐	An Opinion ☐
Secondary Infertility ☐	Egg Timer Test ☐	Fertility Treatment ☐
Recurrent Miscarriage ☐	Donor ☐	AMH blood test ☐
Other (please specify) ☐	Semen Analysis ☐	PCOS Assessment ☐

_____

Past Medical History _____

_____

_____

_____

Allergies _____

_____

Current Medications _____

_____

Recent Investigations (please include copies of results where applicable) _____

_____

_____

_____

Please advise me if my patient doesn't make an appointment ☐

Signed _____

Thank you for your referral. Repromed will inform you regarding the progress of your patient.