

# Repromed

## Referral Form

Northern Territory

If you would like to discuss a patient before referring please contact our Patient Coordinators on **08 8945 4211**

Referring Practitioner Full Name: \_\_\_\_\_  
Practice Address: \_\_\_\_\_  
Practice Phone Number: \_\_\_\_\_  
Provider Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Date of Referral: \_\_\_\_\_

or place stamp here

Dear Dr. \_\_\_\_\_

Thank you for seeing:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Partner (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Patient Phone Number: \_\_\_\_\_

### Referral for (please tick)

Fertility Assessment	Recurrent Miscarriage	Egg Freezing
Fertility Treatment	Ovulation Induction (OI)	Sperm Freezing
Ovarian Reserve Testing	Intra Uterine Insemination (IUI)	Donor Egg
Semen Analysis	In Vitro Fertilisation (IVF)	Donor Sperm
Ovulation Tracking		Surrogacy

Patient Address: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Recent Investigations (where applicable): \_\_\_\_\_

## Thank you

Signed by \_\_\_\_\_