Repromed
Referral Form

South Australia

If you would like to discuss a patient before referring please contact our Patient Coordinators on **08 8333 8111**

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

Patient Address: _____
_____
_____
Allergies: _____
Current Medications: _____
_____
Recent Investigations (where applicable): _____
_____
_____

Thank you

Signed by _____

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South Australia Clinic Locations & Doctors
Please visit our website to learn more

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repromed.com.au

March2026