

# GP/Consultant Referral

Date \_\_\_\_\_

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**Details of Patient(s)**

FEMALE

MALE

First name \_\_\_\_\_

First name \_\_\_\_\_

Surname \_\_\_\_\_

Surname \_\_\_\_\_

DOB \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

Contact Telephone No \_\_\_\_\_

\_\_\_\_\_

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BMI – Female: \_\_\_\_\_

BMI – Male: \_\_\_\_\_

Duration of Infertility:

Primary/Secondary

History:

Fertility Investigations: (please enclose copy if available)

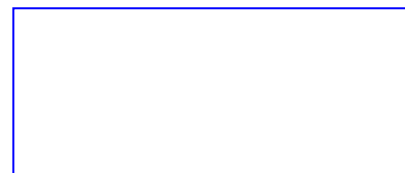
Present Medication:

Other Relevant Information:

**DOCTORS/PRACTICE STAMP**

Doctors Signature

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