origin FERTILITY CARE

GP Referral Template

Date:	

PERSONAL DETAILS OF PATIENT(S)

FEMALE	PARTNER
First Name	First Name
Surname	Surname
DOB	DOB
Address	Address (if different)
Postcode	Postcode
Contact Tel No	Contact Tel No

MEDICAL HISTORY

Duration of Infertility

Primary/Secondary

History

Present medication

Other relevant information

INVESTIGATIONS (Please attach results)

DAY 2/3 FSH/LH	☐	DAY 21 PROGESTERONE	☐
TFT+T4	☐	PROLACTIN	☐
RUBELLA IMMUNITY	☐	CHLAMYDIA SCREENING	☐
RECENT SMEAR TEST (within last 3 years)	☐		

Doctor's signature

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DOCTORS/PRACTICE STAMP

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Author	JH	Issue No.	5
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