

## REFERRAL FOR TREATMENT

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Site

### PATIENT DETAILS

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: **F / M**  
Address: \_\_\_\_\_ PC: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Medicare Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry: \_\_\_\_\_

### CLINICAL DETAILS

- |   |   |
|---|---|
| <input type="checkbox"/> Infertility Management | <input type="checkbox"/> Early Pregnancy Management   |
| <input type="checkbox"/> Endometriosis          | <input type="checkbox"/> Office & Day-Care Gynaecology  |
| <input type="checkbox"/> Recurrent Miscarriages | <input type="checkbox"/> Hysteroscopic Contraception & Sterilisation Procedures (Essure & Ariana) |
| <input type="checkbox"/> PCOS Management        | <input type="checkbox"/> Fibroids / Gynae   |
| <input type="checkbox"/> Egg Donor              | <input type="checkbox"/> Thermablation for Menorrhagia  |
| <input type="checkbox"/> Sperm Donor            | <input type="checkbox"/> Other ( <i>Please Specify</i> ): _____                                   |
| <input type="checkbox"/> Egg Storage            |   |
| <input type="checkbox"/> Sperm Storage          |   |

### REFERRING DOCTORS DETAILS

Doctor: \_\_\_\_\_  
Provider Number: \_\_\_\_\_  
Medical Practice: \_\_\_\_\_  
Address: \_\_\_\_\_ PC: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_