Oxford University Hospitals NHS
NHS Foundation Trust

OVARIAN TISSUE CRYOPRESERVATION (OTCP) REFERRAL FORM

PATIENT DETAILS

Patient Full Name:

Patient DOB:

NHS Number:

Patient Address:

Post Code:

E-mail address:

Patient Telephone Number:

GP Name:

GP Code

GP Address:

Post Code:

REFERRAL DETAILS

Referral Date:

Referring Consultant:

Referring Hospital:

Contact Tel. Number:

Fax Number:

Referring Consultant Address (for correspondence):

CLINICAL SUMMARY

Diagnosis:

Presenting History:

Past Medical History:

Non chemotherapy drugs:

TREATMENT

1. PRE - Ovarian Tissue Cryopreservation treatment:

Chemotherapy/ immunotherapy:

Radiotherapy:

Surgery:

2. POST Ovarian Tissue Cryopreservation treatment (details needed to confirm patient eligibility for OTCP - See 'Eligibility Form' OVF16).

Chemotherapy Agents (list drugs and cumulative doses/m2):

Radiotherapy Site & Dose (list estimated scatter to ovaries/Gy):

Surgery:

If treatment does not fulfil eligibility criteria, please give reasons for referral and contact sheila.lane@ouh.nhs.uk

Planned admission date for treatment:

Date ovarian tissue cryopreservation required:

PUBERTAL STATUS

Is the patient Post-Pubertal? ○ Yes ○ No ***If *YES*, give details below**

Date of last period: Patient's cycles are: ○ Regular ○ Irregular

PLANNED CONCOMITANT PROCEDURES

Central venous line insertion? ○ Yes ○ No Other type of concomitant procedure? ○ Yes ○ No ***If *YES*, give details**

MEDICAL COMPLICATIONS

Does the patient have any medical complications relevant to surgery/general anaesthetic (e.g. diabetes insipidus, VP shunt), previous abdominal surgery?

○ Yes ○ No ***If *YES*, give details**

MANDATORY BLOOD TESTS REQUIRED PRIOR TO REFERRAL: 1) HIV antibody 1&2, Hep B surface antigen, Hep B core antibody, Hep C antibody, Syphilis, HTLV and FSH 2) Full blood count 3) Clotting 4) Electrolytes ***PLEASE ATTACH A COPY OF THE RESULTS***

Has consent for blood testing been given? ○ Yes ○ No

Date sample taken Hospital

Name of person completing form: Title: Date:

Print name: Signature:

Please send this completed form to Oxford Cell & Tissue Biobank (OCTB)

Fax Number : 01865 22 11 50 or secure e-mail: orh-tr.futurefertilitytrust@nhs.net

After completing and sending the form, please also alert Oxford Cell & Tissue Biobank (OCTB) by telephone 01865 22 00 76