Refer to **Monash Health Fertility** via the **Fertility** e-Referral form on HealthLink

All participants in the Fertility journey must have an <u>e-referral</u> submitted through HealthLink in order to access Monash Health Fertility services

Intended Parent/s		Referral submitted for:			
Heterosexual couple		The female (primary) and the male (participant)			
Same sex female couple		Both females (one primary, one participant)			
Same sex male couple		Both males (sperm source primary, partner is participant)			
Singles		The single female or male is the primary patient			
Any and all known donors and identified surrogates also require referrals to be submitted as					
participants in the fertility journey.					
All participants' referrals must be linked to the primary patient by noting:					
Primary Patient Full Name, DOB, and address.					
	Referral Fi	ield	Select		
STEP 1:	Referrar		001001		

STEP 2: **Referral Details** to be completed as standard practice, with clinically relevant details listed. <u>Link participants to primary patient</u> by citing Full Name, DOB, and address.

Requesting treatments or an investigation

Referral Purpose

HL	HealthLink Settings Help -							
	Monash Health	Fertility						
C	Requested Information	Referred To*	Beverley Vollenhoven					
8	Perunty	Referral Date*	26/10/2022					
	Attachments / Departs	Referral Continuation*	New Amended referral/update previously sent referral					
6	Attachments / Reports No reports selected No files allached		Renew expired referral					
	no nos enacios	Referral Period*	12 months V					
4	Medications, Allergies,	Interpreter Required*	O Yes 💿 No					
	Alerts 2 long term medications specified 8 medications specified	Consider for Telehealth consultation	O Yes 💿 No					
	No medical warnings specified	Urgency 🔳	Routine: Greater than 30 days 💙					
	Medical, Social and Family History Medical history specified	Referral Guidelines Before sending your referral, please ensure your patient meets the referral criteria for Fertility. Please click Referral Guidelines to access the specific referral guidelines for this service.						
		Patient Consent*						
No patient nam No patient ID a No date of birth	Patient Information	I acknowledge that patient has agreed to the referral and the shari they are being referred to.	ing of their personal and health information with the health service					
	No patient ID available No date of birth	Referral Purpose*	Requesting treatments or an intervention 🖌					
	Referrer Information	Referral Details* Browse for Consultation Notes						
		Thank you for seeing this patient who presents with						
	Social History, Patient Services and Other Information: Please include relevant information as appropriate							
		Full Name: DOB:						
		Special Needs / Reasonable Adjustments for Disability*	🔿 Yes 💌 No					

Please ensure:

- (1) Referrals for **diagnostic tests** (as per referral guidelines) are provided to the primary patient and all participants in the fertility journey.
- (2) Patients/participants are advised <u>not</u> to book or undertake their diagnostic tests (pathology, imaging, andrology) until contacted by Monash Health Fertility who will assist with appointment coordination. **Monash Health**

1