



Please note: this referral is for LMIT treatment referral and pre-treatment clinical review only. Acceptance is subject to screening verification and clinic criteria. Only Doctors within The Fertility Network may refer patients for LMIT treatment at The Infusion Centre.

REFERRAL DETAILS

Referring fertility specialist:

Provider No.:

Practice / clinic name:

Phone:

Date of Consultation:

System Default Expiry Date:

Use dd/mm/yyyy. Expiry auto-calculates 12 months in supported PDF viewers.

PATIENT DETAILS

Patient full name:

DOB:

Phone:

Email:

Partner / donor name:

Partner / donor DOB:

LIMIT MATCH STATUS

Please indicate the patient's match status:

Partial Match

Full Match

Other / clarification required:

COUNSELLING CONFIRMATION

The referring fertility specialist confirms:

The patient has received counselling regarding LMIT treatment.

The patient has been counselled regarding other available treatment options.

The patient has had the opportunity to ask questions prior to referral.

The patient understands suitability remains subject to clinical review, screening verification and clinic criteria.



SCREENING CONFIRMATION & REPORTS

The referring fertility specialist confirms that:

- checkbox The patient has undergone required LMIT infectious disease screening within 12 months of the proposed treatment date.
checkbox Screening reports are attached or will be provided before treatment.

Date of most recent screening:

[text input box]

Laboratory / Provider:

[text input box]

Table with 3 columns: Required Screening Tests, Completed within 12 months, Report attached / provided. Rows include HIV, Hepatitis B, Hepatitis C, and Syphilis.

CLINICAL INFORMATION

Allergies / adverse reactions:

[text input box]

Weight:

[text input box]

Relevant medical history / conditions:

[text input box]

Current medications:

[text input box]

Additional Information:

EMERGENCY MEDICINE

Approval to administer emergency medication in case of a reaction, if clinically indicated:

Emergency medication approval (tick all approved):

Hydrocortisone

Promethazine

Antihistamine

Doctor's Emergency Medicine Protocol (protocol attached)

Doctor's best contact number in case of emergency:

Doctor signature:

Date:



REFERRING FERTILITY SPECIALIST

By signing below, I confirm that the information provided in this referral is accurate to the best of my knowledge and that the patient has been counselled regarding LMIT treatment and other available options.

Specialist Name: [input field]

Provider No.: [input field]

Practice / Clinic Name: [input field]

Phone: [input field]

Email: [input field]

Date: [input field]

Signature: [input field]

Referral submitted by: [input field]

LOCATIONS



Gold Coast

306 Olsen Avenue,
Parkwood QLD 4214
0449 916 829



Melbourne

Monash House - Level 2,
271 Clayton Road,
Clayton VIC 3168
03 9580 0800



Mackay

Stanley House -
5 Discovery Lane,
Mount Pleasant QLD 4740

SUBMISSION

Please email the completed referral and required screening reports to:

admin@theinfusioncentre.com.au

Required screening reports: HIV, Hepatitis B, Hepatitis C and Syphilis within 12 months of treatment.