BC CANCER
Provincial Health Services Authority

BC Cancer referral for fertility preservation consultation

Patient legal name _____

Preferred name & pronouns_____

PHN _____DOB_____

Address _____

Email _____ Phone number _____

BC Cancer Centre Location _____

Referring Provider:

Name _____ Email _____Phone number _____

Reason for Referral:

Fertility Assessment Yes ☐

Egg/Embryo Cryopreservation Yes ☐

Sperm Cryopreservation Yes ☐

Primary BC Cancer Provider (Oncologist/Radiation Oncologist/Surgeon) to coordinate care:

Name _____ Email _____Phone number _____

Cancer Diagnosis (Type and Stage): _____

Treatment Intent: Curative ☐ Palliative ☐

Is there a known cancer gene mutation (i.e.BRCA1 mutation)? Yes ☐ Specify_____ _____

No ☐

Treatment Plan:

Start date for treatment _____

Systemic therapy protocol _____

Surgery _____

Cranial/pelvic radiation _____

Patient Clinical Status:

If female, last known menses: _____

Suitable to travel to clinic? Yes ☐ No ☐

Suitable to receive procedural sedation? Yes ☐ No ☐

Patient Co-morbidities: _____

Relevant surgical history: _____

BC Cancer Care Team:

Primary BC Cancer Provider to coordinate care:

Name _____ Email _____Phone number _____

Oncologist (if applicable)

Name _____ Email _____Phone number _____

Radiation Oncologist (if applicable)

Name _____ Email _____Phone number _____

Surgeon (if applicable)

Name _____ Email _____Phone number _____

Adjuvant Treatment for Patients Assigned Female at Birth:

Oocyte/Embryo cryopreservation typically requires 2 weeks.

Does the cancer care team (which includes the patient) support a plan to take the time required to:

Proceed with fertility preservation? Yes ☐ No ☐

Receive hormone stimulation? Yes ☐ No ☐

Additional notes: _____

_____

_____

Please forward this referral together with:

- Any relevant imaging/pathology/surgery reports
- Bloodwork panel required (please order):
  – CBC; HIV 1 + 2 Ab and HIV 1 p24 Ag; Hepatitis B sAg; Hepatitis C Ab; Treponema pallidum Ab EIA (Syphilis screen)
- Send report of Anti-mullerian hormone levels if available for Patient/Assigned Female at Birth

To Refer:

Send this form by fax to one of the two fertility clinics offering full cryopreservation services in BC. The referral will be triaged as urgent and the patient will be contacted to make an appointment within a few days.

Olive Fertility Centre – Main Centre
300-East Tower, 555 West 12th Avenue,
Vancouver, B.C. V5Z 3X7
Tel: 604.559.9950
Fax: 604.559.9951

Olive Fertility Centre – Victoria
545 Superior Street, Suite 210, Victoria B.C. V8V 0C5
Tel: 250.410.1664
Fax: 250.999.8838

https://www.olivefertility.com

Other sites are available for initial consultation in Kelowna, Surrey and Prince George.

Pacific Centre for Reproductive Medicine (PCRM) – Main Centre
500 - 4601 Canada Way
Burnaby, B.C. V5G 4X7
Tel: 604.422.7276
Fax: 604.434.5522

https://pacificfertility.ca
Another site is available for initial consultation in Victoria.

Other fertility and health centres are available in B.C. that offer services beyond fertility preservation including support for fertility assessment, assisted reproduction and sexual health.

For more information on fertility preservation in BC, please visit the BC Cancer AYA Oncology Care & Support.

anew
Reshaping young adult cancer care, together.

BC Children's Hospital
Provincial Health Services Authority

CANADIAN PARTNERSHIP AGAINST CANCER

Royal Roads UNIVERSITY