

## Referral for Male Fertility Preservation related to Gonadotoxic Treatment

With the support of the NSW Ministry of Health, Westmead Fertility Centre (WFC) offers fertility cryopreservation services to patients prior to or after the completion of gonadotoxic treatment. These fertility cryopreservation services are provided at no cost for Medicare cardholders who reside in NSW.

***Please note that Westmead Fertility Centre does not offer cryopreservation and cryostorage for any patient aged 60 or older. If the patient you are referring is 56 or older, this may impact how long they can keep their semen cryostored at Westmead Fertility Centre.***

To ensure efficient service for your patient, please follow the instructions below:

1. Provide the patient with a copy of the Consent for Semen Cryostorage (CF-26 attached) for their review and consideration prior to their appointment with WFC.
2. Complete all details in the referral form (FC-51.2 attached). Please be sure to complete all fields for the patient and the referring specialist, as incomplete forms will be returned, which may result in a treatment delay for your patient.
3. Email the following documents to [wfc.oncology@sydney.edu.au](mailto:wfc.oncology@sydney.edu.au).
  - a. Compliant, fully completed referral form (FC-51.2 attached)
  - b. Blood test results for Hep B Surface Antigen, Hep C Ab and HIV Ab noting Fertility Preservation services for your patient cannot proceed without available blood results. These blood results must be provided by the referring physician with the referral form FC-51.2.
4. **Patient (or representative) can make an appointment for their sample collection by calling 02 8890 7484.**
5. Review of results:

The banking outcome will be forwarded to the referring Doctor.

The patient must undertake a phone consultation with a fertility specialist to ensure that up to 10 years of storage costs are covered by state and / or federal governments, and to advise the patient of their obligations to maintain contact with WFC for continued storage. Due to the urgency of treatment, it is often not feasible for consultation to happen prior to treatment and so the patient may attend this phone consult post freeze.

**Please be aware that all referrals are handled Monday – Friday between 7.30am – 3.00pm. Referrals received outside of these hours will be responded to on the next business day.**

**If you, as the referring doctor, wish to speak to a Fertility Specialist about your patient, please contact the WFC Fertility Fellow or the Fertility Specialist on call, through Westmead Hospital switchboard (02 8890 5555).**

# Referral for Male Fertility Preservation

Prior to or after gonadotoxic treatment

## PATIENT DETAILS

SURNAME.....FIRST NAME.....  
EMAIL.....D.O.B.....  
ADDRESS.....  
MOBILE.....MRN.....  
MEDICARE CARD NUMBER: .....  
INDIVIDUAL REFERENCE NUMBER..... EXPIRY.....

## GUARDIAN DETAILS [IF PATIENT UNDER 18 YEARS OF AGE]

FULL NAME.....MOBILE.....

Referring Specialist

### Recent or Planned Treatment:

This patient  has received  will be receiving gonadotoxic treatment for a medical condition.

CIRCLE

NucMed Scan: .....Start Date:..... Completed? Yes / No  
Chemotherapy: .....Start Date:..... Completed? Yes / No  
Radiotherapy: .....Start Date:..... Completed? Yes / No  
Surgery: .....Start Date:..... Completed? Yes / No  
Other: .....Start Date:..... Completed? Yes / No

### Infectious Status:

WFC requires the patient's infectious status for HIV, Hep B Surface Antigen and Hep C (dated within the last two years). Please send an electronic copy along with this form.

### Requesting Specialist:

By signing this referral form I declare that this patient is eligible for Medicare Item #13260 outlined below:

*The processing and cryopreservation of semen (not including storage) for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions in a post-pubertal male in Tanner stages II-V up to 60 years old- one of a maximum of two semen collection cycles per patient in a lifetime.*

*A semen cycle collection process involves obtaining up to 3 semen samples on alternate days producing up to 50 cryopreserved straws of frozen sperm.*

*Maximum of two semen collection cycles, one cycle collected prior to a patient undergoing the first cytotoxic/radiation treatment and the second if the patient has relapsed and requires treatment.*

Full Name:.....

Position (Non-WFC): .....Provider No. (Non-WFC): .....

Email (Non-WFC): .....

Mobile Number (Non-WFC): .....

Signature: ..... Date: .....

### Patient Instructions:

- Samples will be received by appointment only. To make an appointment, please call Westmead Fertility Centre on **(02) 8890 7484**
- You will receive a map to the Andrology Laboratory of Westmead Fertility Centre, located inside Westmead Hospital.
- You **MUST** bring your photo ID and Medicare card to the Andrology Lab appointment.
- Please abstain from intercourse or ejaculation for 3 days prior to this appointment.

This form is to be submitted to [wfc.oncology@sydney.edu.au](mailto:wfc.oncology@sydney.edu.au). Please call **(02) 8890 7484** if you have any questions.

E: ..... M.Care Name.....M.Care #..... Indiv. Ref #.....

Attended Andrology Appointment  Collected  Freezing Completed

Admin Only



# Consent for Semen Cryostorage

SURNAME.....	SEX:.....
FIRST NAME.....	DOB:.....
HOME ADDRESS.....	
SUBURB.....	POSTCODE:.....

1. By signing this consent form I confirm that the doctor / Scientist whose signature appears below has explained the nature of SEMEN CRYOSTORAGE and the associated risks and consequences to me in a language I understand. I am satisfied with the explanation and the answers to my questions.
2. I have been informed about my rights and responsibilities as a patient of Westmead Fertility Centre. I am aware Westmead Fertility Centre's website: [www.westmeadfertilitycentre.com.au](http://www.westmeadfertilitycentre.com.au) has current information available regarding the cryostorage cost. I agree to pay any applicable fees before commencing and for the duration of cryostorage as required. I acknowledge that if I wish to transfer my cryostored semen *from* Westmead Fertility Centre to another facility, an administration fee will be payable.
3. I consent to the storage of my semen sample for *up to* five (5) years from the date supplied and understand there will be associated monthly fees for storage.
4. I understand that there are a number of circumstances in which Westmead Fertility Centre will cease to store my gametes and will allow them to succumb and be discarded **prior to the end of the 5-year period** as set out below.

### ***What happens to my gametes when I turn 60 years of age?***

5. I understand that:
  - a. Westmead Fertility Centre does not provide treatment with assisted reproductive technology, including cryostorage, to men over 60 years of age; and
  - b. once I reach the age of 60, storage will be terminated, and my semen sample will be allowed to succumb and will be discarded.

### ***What happens to my semen sample if I do not make a monthly direct debit payment for storage?***

6. I understand that a storage fee (payable monthly) will apply for cryostorage at Westmead Fertility Centre. I understand that I am to contact Westmead Fertility Centre if I do not receive a request to set up these payments and / or if my contact and / or payment details require updating. I understand that my consent for Westmead Fertility Centre to continue storage is confirmed by this monthly payment and failure to make this monthly payment will indicate that I no longer wish to continue storage. If Westmead Fertility Centre has not received the storage fee, I authorise Westmead Fertility Centre to terminate my storage and allow my semen sample to succumb and be discarded.

### ***What happens to my semen sample after 5 years (if I have made my direct debit payments and have not reached 60 years of age)?***

7. I understand that if I do not sign a further consent form for continued cryostorage within 28 days of the end of the 5 year storage period, storage will be terminated and my semen sample will be allowed to succumb and will be discarded. I understand that this will happen even if I have made all my monthly direct debit payments for the 5 year storage period, and I have not yet reached 60 years of age.
8. I understand that I may change or withdraw consent at any time during the storage period.
9. I understand that the cryostorage process will reduce the quality of my semen sample. The success rate of my treatment may be reduced. I am aware use of my cryostored semen sample may not result in a successful pregnancy even when treatment with assisted reproductive technology is carried out with due professional care.
10. I understand that Westmead Fertility Centre makes every effort to minimise the risks during laboratory handling, freezing and storage of my semen sample. I recognise there are some unavoidable risks associated with each of these procedures for which Westmead Fertility Centre cannot be held responsible. These include, but are not limited to:
  - a. damage to sperm as a result of power failure, laboratory equipment faults or during handling or storage;
  - b. risk of damage to the vessels containing the sperm during the transport, storage and freezing processes;
  - c. cryodamage to sperm during the freezing or thawing process; and
  - d. risk of deterioration of labelling therefore rendering the sperm unidentifiable and unusable.



SURNAME.....	SEX:.....
FIRST NAME.....	DOB:.....
ADDRESS.....	
SUBURB.....	POSTCODE:.....

11. I understand that laws in NSW may restrict the use and cryostorage of the cryostored semen sample in the event of my death or if I am unable to give consent or vary consent (eg due to post-coma unresponsiveness), unless I have recorded my wishes about the use of my semen sample in such circumstances. I outline my wishes below:
- If the table below is NOT completed, it will be assumed NO posthumous use or cryostorage is permitted and the semen sample will be allowed to succumb and be discarded.
  - Without the consent and signature from the named spouse / de facto partner, the consent to export the semen sample will be invalidated and the semen sample will be allowed to succumb and be discarded.

<p><b>I DO</b> consent to the exportation of my semen sample for use elsewhere if I am deceased or unable to vary this consent by (insert name) ..... in their complete discretion. (NOTE – <b>this can only be spouse / de facto partner.</b>) Please provide contact details of the named spouse / de facto partner below.</p>	<p>..... <b>(Patient Signature)</b></p>
<p>Spouse / de facto partner to complete where applicable. I consent to being responsible for the exportation of the gametes:</p> <p>Name: ..... Signature: .....</p> <p>Address: .....</p> <p>Phone Number: ..... Email: .....</p> <p>Date of Birth: ..... Relationship to Individual Named on this Form: .....</p>	

12. I understand that Westmead Fertility Centre does not offer services to patients for posthumous use of semen. Upon request, Westmead Fertility Centre will provide assistance in exporting your semen to another clinic.
13. I have been informed about the availability of counselling services at Westmead Fertility Centre.
14. I have read Westmead Fertility Centre’s Privacy Policy and signed the Privacy Collection Statement. (Where applicable) I give consent for the record created by Westmead Fertility Centre to contain the personal information of both partners and for both partners to have access to the record including the other partner’s personal information.
15. I acknowledge receipt of a copy of this consent form.

	Name	Signature	Date
<b>PATIENT</b>			

I confirm that I have explained the above process and treatment and its risks and benefits to the above persons.

	Name	Signature	Date
<b>WITNESS</b>			
<p><b>Where applicable, witness to sign or initialise:</b> I confirm that this document was signed in counterpart and witnessed over audio visual link in accordance with section 14G of the Electronic Transactions Act 2000 (NSW).</p>			

If interpreter present, signature of interpreter \_\_\_\_\_ NAATI Number \_\_\_\_\_