METROCENTRE
VASECTOMY AND VASECTOMY REVERSAL

REFERRAL

Date:

Patient Name:

DOB:

Referral for consult & assessment of patient for

(please tick) ✓

- ☐ Vasectomy Procedure
- ☐ Micro-surgical Vasectomy Reversal
- ☐ Post Vasectomy Pain
- ☐ Varicoeles

Patient History:

Referring Practitioner:

Signature:

Provider Number and Address:

LOCATION

- ☐ Gold Coast
- ☐ Brisbane
- ☐ Sydney
- ☐ Melbourne
- ☐ Cairns
- ☐ Mackay

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