METROCENTRE
VASECTOMY AND VASECTOMY REVERSAL

REFERRAL

Date: _____

Patient Name: _____

Patient Phone Number: _____

Date of Birth: _____

Referral for consult & assessment of patient for -

(please tick) ✓

- ☐ Vasectomy procedure
- ☐ Micro-surgical vasectomy reversal
- ☐ Post-vasectomy pain
- ☐ Varicoceles

Patient History: _____

_____

_____

_____

Referring Practitioner: _____

Signature: _____

Provider Number and Address:

Location:

- ☐ Gold Coast
- ☐ Brisbane
- ☐ Sydney
- ☐ Melbourne

PH: 1800 FOR MEN (1800 367 636)
www.metrocentre.com.au

New referral pad orders available on our website