verve
MEN'S CLINIC

Dr Philippe Wolanski *MBBS, FRACS (Urol)*
Dr Jonathan Fenton *MBChB, BSc (Hons), FRACGP*

Patient Details:

Family name: _____
First name: _____
DOB: ___/___/____
Address: _____
_____
Contact number: _____

PATIENT REFERRAL FORM

INDICATIONS

☐ **ERECTILE DYSFUNCTION**

☐ Investigation/Management
☐ Intracavernosal injection initiation/training

a. Duration of ED: _____
b. Treatments tried to date: _____
c. Risk factors:

☐ Diabetes ☐ Smoking ☐ Hypertension
☐ Dyslipidaemia ☐ CV disease ☐ Stroke/CVA
☐ Alcohol excess ☐ Other drug use ☐ Poor sleep
☐ Depression
☐ Pelvic/Rectal/Prostate surgery: _____
☐ Other: _____

☐ **PEYRONIE'S DISEASE**

☐ **PREMATURE EJACULATION**

☐ **TESTOSTERONE DEFICIENCY**

Additional information (optional):
_____
_____
_____

Please list the patient's current medications: _____
_____

Referrer details *(or practice stamp)*:

Name:
Practice:
Provider number:

Signature:
Date:

◯ *Electronically signed*

Please send to:
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