Dear patient,

I set up the **Telemedicine Reproductive Services** with the desire to better meet the needs of my patients. You are all busy people and the availability of a 20 minutes session for a consultation is scarce.

The **advantages** that I have identified are:

1. No waiting list
2. All appointments done on line, no need to spend time contacting my secretary
3. No need to find or pay for parking
4. Generous consultation duration, fixed start and finish allowing planning your calendar
5. No need to spend time in a waiting room
6. All registration already processed
7. All test results should be available and ready for discussion - **please see recommended tests at** [**www.edgarmocanu.eu**](http://www.edgarmocanu.eu)
8. No contact with the hospital, clinic waiting room environment
9. Comfort of work or home and detachment from the “face to face” stress
10. Keeping a cool mind and ensuring all your questions are answered

There are also **limitations**:

1. No physical assessment possible
2. No ultrasound possible at first visit (if you already had a scan it will be discussed with you)
3. The risks inherent in the use of any virtual platform

I encourage all my patients to avail of a scan midcycle (day 10 or 11 or 12) to assess follicular growth and if any pathology is present. This scan should be done even if you had a scan before confirming no abnormalities. It is **booked by you (01 8742115 or email: privateclinic@rotunda.ie)** via the Private Clinic.

You have the choice to avail of a formal, in person, consultation or **if you wish to avail of a telemedicine consultation please sign the consent below, fill in the information in detail** (it will form the basis of my understanding of your specific circumstances) **and forward to my academic email:** **emocanu@rcsi.ie**.

If your appointment request is for **surgery**, I will discuss all the details of the procedure with you and set up a date and hospital location for you. Ideally, you would have had an ultrasound of your pelvis. If not, I will organise same. For details please visit my surgery page at: <https://www.edgarmocanu.eu/our-services/reproductive-surgery/>

I look forward to offering you a clear and comprehensive review of your specific circumstances and advice on how to overcome current fertility challenges or surgical needs.

Thank you for booking an appointment with me,

**Dr. Edgar Mocanu MD FRCOG FRCPI Dip Ethics**

Sub-Specialist in Reproductive Medicine and Surgery

Consultant Gynaecologist

MCRN 19881

emocanu@rcsi.ie

[www.edgarmocanu.eu](http://www.edgarmocanu.eu)

**Request for consultation and consent**

We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request and agree to participate in a Telemedicine Fertility Consultation with Dr. Mocanu using the **ZOOM**, end to end encrypted platform. We understand no online service can achieve 100% guaranteed confidentiality and that **ZOOM** has an encrypted service that offers reassurance from this perspective.

We understand we have the opportunity not to avail of this service and organise a traditional (in person consultation) with Dr. Mocanu by ringing 01874 2115 and joining the waiting list.

We request and agree that a letter detailing our consultation could be forwarded to our GP. YES NO

Please insert GP details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We understand Dr. Mocanu will use the confidential information provided for the purpose of contacting us, forming a medical opinion, offering us medical advice and that said information will be stored safely and securely and kept no longer than necessary. Apart from the letter to your referring physician, this information will not be disclosed to any third party without our specific request and consent, unless stipulated by law.

We understand that the Telemedicine Consultation cannot proceed without this consent being signed.

We read the benefits and limitations of the Telemedicine Fertility Consultation detailed above and decided to proceed with this medical consultation.

**Patient 1 Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/2021

**Patient 2 Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/2021

**PERSONAL DETAILS**

**FEMALE** First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_*

**Contact** Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical insurance provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupational risks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(FE)MALE/** First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_*

**Contact** Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical insurance provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Number: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupational risks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP / Consultant name and address for correspondence:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You give Dr. Mocanu permission to write to your GPYes No

You give Dr. Mocanu permission to write to your Consultant Yes No

Any special requests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE partner**

**Age at first period:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Trying for how long:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First day of last menstrual period:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ever pregnant?** Yes No Current partner Previous partner

**Outcome of pregnancies:**

1.

2.

**Periods** Bleeding \_\_\_\_\_\_\_ days Every \_\_\_\_\_\_\_ days Pain Heavy

**Gynaecological complaints (delete when not applicable)**

 Endometriosis Fibroids Abnormal smears Ovarian cysts LLETZ

**Any surgery you had in the past?**

1.

2.

**Any medical conditions you have? Y**es No

1.

2.

**Any medical or genetic diseases in your family?** Yes No

1.

2.

**Do you take any medication?** Yes No

1.

**Do you have any allergies (list)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** Yes ( /day) No **Alcohol intake** ( /week)

**Date of last smear test:** \_\_\_\_\_\_\_\_\_\_\_\_ **Smear result:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your BMI?** \_\_\_\_\_\_\_ (kg/cm2)

**How often do you have intercourse?** \_\_\_\_\_\_\_\_ / week

**Any issues with intercourse?** No Yes, details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE/ FEMALE partner**

**Have you ever fathered a child?** Yes No Current partner Previous partner

Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any health issues with the child (ren)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you ever have:**

 Mumps affecting your testicles Trauma to your genitalia

Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any surgery you had in the past ?**

1.

**Any medical conditions you have?** Yes No

1.

2.

**Any medical or genetic diseases in the family?** Yes No

1.

2.

**Do you take any medication?** Yes No

1.

**Do you have any allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke?** Yes ( /day). No **Alcohol intake** ( /week)

**Are you exposed to a toxic environment at work?** Yes No

**Details** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your BMI?** \_\_\_\_\_\_\_ (kg/cm2)

**Any issues with intercourse?** No Yes **Details** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you have a semen analysis done to date?** Yes No

**Was the result** : Normal Abnormal **Please forward**

**Previous fertility tREATMENTS**

**Ovulation induction** (Tablets to grow eggs)

Medication used

Duration of treatment

Outcome Pregnant Not pregnant Miscarriage Ectopic

**IUI** (Artificial insemination, intra-uterine insemination)

Date of therapy \_\_\_\_\_\_\_\_\_\_\_\_

Medication used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outcome Pregnant Not pregnant Miscarriage Ectopic

**IVF/ ICSI** (In vitro fertilization, Intra Cytoplasmic sperm injection)

Date of therapy \_\_\_\_\_\_\_\_\_\_\_\_\_

Medication used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose changes No Yes \_\_\_\_\_\_\_\_\_\_\_\_ Duration of stimulation \_\_\_\_\_\_\_ days

Trigger medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of eggs collected \_\_\_\_\_\_\_\_

How many eggs fertilized \_\_\_\_\_\_\_\_\_\_\_\_ Transfer Yes No

Day of transfer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of embryos transferred \_\_\_\_\_

Outcome Pregnant Not pregnant Miscarriage Ectopic

Adjuvant therapies used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Donor therapies**

Please provide details:

Any other relevant issues that I should know about or you would like to talk about during our consultation? Please detail below.

***~End of document~***