

## Tertiary Fertility Services

Patient Consent	<i>Tick as appropriate</i>	Yes	No
Is the patient aware of this referral and the content of this form?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
By submitting this request, you are confirming that you have fully explained to the patient why they are eligible for NHS treatment, and they have consented to you submitting this referral.			

**Referrals to fertility specialist services must be made by the secondary care provider following prerequisite investigations or treatments required, which may be undertaken at either the primary level or secondary level as appropriate**

Once fully completed please submit this form to the following email address:  
[mseicb.ifrfunding@nhs.net](mailto:mseicb.ifrfunding@nhs.net)

Patient Information			
Name:			
Address:		NHS No:	
		Home Tel No:	
		Mobile Tel No:	

Partner Information			
Name:			
Address:	DOB:		
	NHS No:		
	Home Tel No:		
	Mobile Tel No:		

GP Information			
Name:			
Address:	GP F-code	Telephone No:	
	NHS net email address:		

<b>Date of Initial GP Referral:</b>	
-------------------------------------	--

<b>Name of Referring Consultant</b>		<b>Telephone number:</b>	
<b>Hospital of Referring Consultant:</b>			
<b>Hospital/Hospital number</b>			

<b>Date of Consultant Referral:</b>	
-------------------------------------	--

<b>Is an interpreter required?</b>	<b>Yes</b>	<b>No</b>	<b>If 'Yes' what language (including sign language)</b>	
	<input type="checkbox"/>	<input type="checkbox"/>		

<b>Criteria</b>	<b>Response</b>		<b>Eligible (tick as appropriate)</b>			
			<b>Yes</b>	<b>No</b>		
<b>Duration of infertility:</b>	Years:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>Diagnosed cause of absolute infertility (please state)</b>	State:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>At least 2 years infertility (2 years of ovulatory cycles) despite regular unprotected vaginal sexual intercourse with the partner seeking treatment or a diagnosed cause of absolute infertility:</b>	State:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>Previous IVF/IUI cycles (whether self or NHS funded)</b>	Number:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>Age of female at date of referral to IVF provider service (policy states female must be between their 23rd and 42<sup>nd</sup> birthday)</b>	Years:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>BMI of female at date of referral to IVF provider service (policy states more than 19kg/m<sup>2</sup> and less than 30kg/m<sup>2</sup>)</b>	BMI:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>BMI of male at date of referral to IVF provider service (policy states less than 35kg/m<sup>2</sup>)</b>	BMI:		<input type="checkbox"/>	<input type="checkbox"/>		
<b>FSH level on day 2 of cycle within 3 months: (policy states less than 9)</b>	Level	<b>Date FSH completed</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Both individuals in the couple must be ordinarily resident in the UK and have been registered with a GP within Mid and South Essex ICB for a minimum of 12 months</b>	Yes/no	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b><u>Not eligible</u> if answer 'yes' to any of these questions:</b>						
<b>Do either of the couple smoke?</b> (Please note couples must be non-smokers at the time of treatment).	<b>Yes:</b>	<input type="checkbox"/>	<b>No:</b>	<input type="checkbox"/>		
<b>Living Children</b> • There should be no surviving children from this relationship including adopted children but excluding fostered children.	<b>Yes:</b>	<input type="checkbox"/>	<b>No:</b>	<input type="checkbox"/>		
• There should be no children from previous relationships	<b>Yes:</b>	<input type="checkbox"/>	<b>No:</b>	<input type="checkbox"/>		
<b>Have either partner been sterilised?</b>	<b>Yes:</b>	<input type="checkbox"/>	<b>No:</b>	<input type="checkbox"/>		

Procedure/treatment required	Please complete as required
<b>IVF with or without ICSI (Standard package will include)</b> <ul style="list-style-type: none"> <li>• Initial consultant, follow up consultant, and counselling session.</li> <li>• All ultrasound scan and hormone assessment during the treatment cycle</li> <li>• Oocyte stimulation</li> <li>• Oocyte recovery – by vagina ultrasound guided aspiration under sedation or local anaesthesia: laparoscopy as appropriate under general anaesthesia</li> <li>• IVF or ICSI to produce embryos and blastocyst culture as appropriate</li> <li>• Embryo, or blastocyst transfer, into uterine cavity.</li> <li>• Pregnancy test and max two scans to establish pregnancy viability</li> <li>• Drug costs and sperm preparation</li> </ul>	<input type="checkbox"/>
<b>Embryo/blastocyst freezing and storage</b> Commissioned as part of the service requirement, and will be funded for up to 12 months following completion of NHS Treatment	<input type="checkbox"/>
<b>Surgical sperm recovery</b> (TESA/PESA including storage where required) Will be funded for up to 12 months following completion of NHS Treatment	<input type="checkbox"/>
<b>Donor oocyte cycle</b> For individual with embryo/blastocyst stored	<input type="checkbox"/>
<b>Donor Sperm insemination</b>	<input type="checkbox"/>
<b>Egg and sperm storage for patients undergoing cancer treatments</b> Cryopreserved material may be stored for an initial period of 5 years. (Please see Eligibility Criteria)	<input type="checkbox"/>

Clinical Information	
Number of TOPs:	
Number of miscarriages/ectopics:	

Investigations Female		
	Date:	Result:
Ultrasound or pelvic/uterine assessment (specify procedure carried out:		
LH (day 2-4):		
Estradiol (day 2-4):		
Tubal Patency		

Investigations Male			
Semen Analysis:	Date:		Volume:

<b>Sperm Count:</b>	<b>Progressively motile:</b>	<b>Normal forms:</b>
---------------------	------------------------------	----------------------

<b>Sperm storage (if required)</b> <input type="checkbox"/>	
<b>Nature of diagnosis required this procedure:</b>	<b>Date of diagnosis</b>
<b>Planned treatment/surgery</b>	<b>Treatment start date:</b>
<b>Please also complete HIV, HEP B/C status</b>	

<b>Any other relevant information, e.g. allergies:</b>
--

<b>Screening (within last 3 months)</b>				
<b>Test</b>	<b>Female</b>		<b>Male</b>	
	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
<b>HIV Screening</b>				
<b>Hep B Surface Antigen</b>				
<b>Hep B Core Antibody</b>				
<b>Hep C</b>				

<b>Screening (within last 12 months)</b>				
<b>Test</b>	<b>Female</b>		<b>Male</b>	
	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
<b>Chlamydia Screening</b>				
<b>Haemoglobinopathy Electrophoresis (if indicated)</b>				
<b>Rubella</b> (within the last 5 years)				
<b>Cervical Smear</b> (within the last 3 years, as per screening pathway)				

<b>Welfare of the Unborn Child</b>	<i>Tick as appropriate</i>	<b>Yes</b>	<b>No</b>
------------------------------------	----------------------------	------------	-----------

Are you aware of anything in the past medical or social history of either partner, which may be of concern with regards to the welfare of the unborn child?	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

If the answer is 'Yes', but you still wish to refer the couple, please provide full details of any relevant concerns or extenuating circumstances

Please include any other relevant blood tests result, investigations or information.

PLEASE SIGN AND DATE THIS BOX: Funding approval is requested by	
Name of Clinician	
Contact number	
Date	

FOR ICB COMPLETION ONLY	
<b>DECISION:</b>	Choose an item.
Name	
Signature	
Date	
Reference number	
Number of Cycles Approved	