**GP Referral Form for Infertility Services at BHRUT**

Date:

**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| NHS Number: |  | **Address:** |  |
| Hospital Ref: |  |  |
| Surname: |  |  |
| First Name: |  |  |
| Date Of Birth: |  | **Phone:**  **Email:** |  |
| Main Language: |  | Interpreter needs: | |
| Communication needs: | | | |

|  |  |
| --- | --- |
| **Relationship status:** i.e. married/civil partnership/partners/separated/divorced/single |  |

**Partner Details**

|  |  |  |
| --- | --- | --- |
| NHS Number: |  | **Address**: |
| Hospital ref: |  |  |
| Surname: |  |  |
| First name: |  |  |
| Date of Birth: |  | **Phone:**  **Email**: |
| Main Language: |  | **Interpreter needs:** |
| Communication needs: |  |  |

**GP Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Referred By:** |  | |  | **Practice name and phone number / practice stamp** |
| **Usual GP:** |  | |  | **FORMTEXT FORMTEXT FORMTEXT FORMTEXT**  **Tel:**  **Email:** |
|  |  | |  |
| **Practitioner’s Number:** | |  |  |

**Clinical Details**

**Please ensure all mandatory fields in red are up to date otherwise the referral will not be accepted.**

|  |  |
| --- | --- |
| **Age**  *(Women should be referred so that they can commence treatment cycle before* ***43*** *birthday)* |  |
| **Children in this relationship** | **Mandatory** |
| **BMI**  *(BMI must be* ***£ 30*** *at time of referral)* | **Mandatory** |
| **Smoker?**  *(Couple must both be non-smokers)* | **Mandatory** |
| **Duration of infertility in this relationship** |  |

|  |  |
| --- | --- |
| **Past Medical/Surgical History** |  |
| **Medication** |  |
| **Allergies** |  |
| **Social History**  *(substance intake, any safeguarding issues etc)* |  |
| **Cervical smear** |  |
| **Rubella status**  **(If not immune, please ensure 2 doses of MMR are given prior to being referred)** | **Mandatory** |
| **HBO status (if accessible)** |  |
| **Any genetic history in the patient or partner (carrier or disease e.g but not limited to Cystic Fibrosis, Sickle Cell, Thalassemia, Polycystic Kidney Disease)** |  |
| **Any other relevant information** |  |

**Please attach the following information;**

**Other relevant baseline clinical measures**

* Weight:

**FBC (within last 12 months)**

* Haemoglobin (within last six months):
* Platelets:
* MCV:

**Other Blood Tests**

* HIV/Hepatitis B Surface antigen / Hepatitis B core/ Hepatitis C ( **Both partners if applicable**)
* Haemoglobinopathy Screen **(Sickle Cell / Thalassaemia)**
* Rubella status

**Endocrinology**

* Day 2-4 FSH/LH/E2 (26 – 35-day cycle only)
* TSH
* Prolactin

**Other Investigations:**

* Chlamydia/ Gonorrhoea

**Investigations for the partner: (please attach if you have the results already)**

* HIV/Hepatitis B Surface antigen / Hepatitis B core/ Hepatitis C

**Important**

Individuals cannot be referred to this service; they mustbe seen as part of a couple.

Each male referral MUST have the female partner’s name and date of birth on it. They must have been trying to conceive with their current partner for at least 12 months, both must be resident in the UK for at least one year and both registered with their current GPs for at least 12 months.

If the patient is under colposcopy, they should not be referred for an appointment until they are six months clear.

Exclusion from free of charge services

**Immigration health surcharge.** Patients who have paid the immigration health surcharge are **NOT** entitled to receive assisted conception services free of charge. If patients confirm that they have paid the immigration health surcharge, you must advise them of this.