**Please note that all requested fields in red are mandatory and failure to complete these may result in a rejected referral.**

**Date of referral:**

**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 |  |
| **Residency status: i.e. Ordinarily resident, indefinite leave to remain, EU settled status etc.** [NHS entitlements: migrant health guide - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide) |  |

**Partner 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 |  |
| **Residency status: i.e. Ordinarily resident, indefinite leave to remain, EU settled status etc.** [NHS entitlements: migrant health guide - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide) |  |

**GP Details**

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

**Clinical Details**

|  |  |
| --- | --- |
| **Patient Age*****(Women should be referred so that they can commence treatment cycle before 45 birthday)*** |  |
| **BMI*****(BMI must be <35 at time of referral)*** |  |
| **Allergies**  |  |
| **Cervical smear** ***(Must be up to date)*** |  |
| **Day 2-4 FSH/LH/E2 (26 – 35-day cycle only) results** |  |
| **Past Medical/Surgical History**  |  |
| **Medication**  |  |
| **Duration of infertility in this relationship** |  |
| **Children in this relationship** |  |
| **Social History (if known)***(substance intake, any safeguarding issues etc)* |  |
| **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: / BMI:

**Endocrinology (mandatory)**

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

**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

**Other Investigations:**

* Chlamydia

**Investigations for the partner:**

* Semen Analysis (within the last 12 months if available)
* HIV/Hepatitis B Surface antigen / Hepatitis B core/ Hepatitis C (if available)