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**Referral Form for Fertility Assessment**

 **EFFECTIVE FROM December 2014 – ALL NEW GP REFERRALS**

**Criteria for Referral for Assessment by Fertility Services:**

1. In order to refer a couple for assessment all questions **MUST** be answered.
2. Please refer to your local CCG policy for details of eligibility criteria for assisted conception treatments including Intrauterine Insemination (IUI), Donor Insemination (DI), Oocyte Donation (OD) and in-vitro fertilisation (IVF).
3. If referring for IVF treatment, read eligibility criteria in policy [www.enhertsccg.nhs.uk/ivf](http://www.enhertsccg.nhs.uk/ivf) prior to referral.

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| --- |
| **Patient Information** |
| **Name:** |  |
| **Address:** |  | **DoB:** |  |
| **NHS No:** |  |
| **Home Tel No:** |  |
| **Mobile No:** |  |
| **Partner Information** |
| **Name:** |  |
| **Address:** |  | **DoB:** |  |
| **NHS No:** |  |
| **Home Tel No:** |  |
| **Mobile Tel No:** |  |
| **GP Information** |
| **Name:** |  |
| **Address:** |  | **Telephone No:** |  |
| **NHS net email address:** |
|  |
| **Referral date:** |

**To be completed by GP prior to referral to secondary care**

|  |  |
| --- | --- |
| **Initial Lifestyle advice** | **Tick** |
| Provide patient information on conception rates and reassurance |  |
| Consider referral to smoking cessation and weight management |  |
| Advise on alcohol intake and recreation drug use  |  |
| Recommend folic acid supplementation |  |
| Other lifestyle advice (tight underwear, occupation) |  |
| GP registered or residency in CCG area for at least 12 months |  |
| Establish by direct questioning to both parents if there is any reason due to past medical or social history of either partner, which may be of concern with regard to the welfare of the unborn child? ( *this includes history of social care, crime against a child*) *Answer yes/no. If the answer is ‘Yes’, but you still wish to refer the couple, please provide full details of any relevant concerns or extenuating circumstances* |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Any other relevant information, eg allergies, medical history requiring pre-conceptual care ie diabetes, epilepsy, genetic conditions and others.****If yes to the above please confirm that referral for pre-conceptual care has occurred.**  | Yes:Yes: |  | No:No: |  |

**Failure to conceive after 1 year attempt or 6 cycles of artificial insemination- further investigations and consider referral to secondary care.**

|  |  |
| --- | --- |
| **Investigations** | **Date** |
| **Female** |
| Regular menstrual cycle | [ ]  YES  | [ ]  NO |
| Serum FSH Level (Day 1-3) |  |  |
| Serum LH Level (Day 8) |  |  |
| Serum Progesterone at mid-luteal: |  |  |
| Serum Prolactin: |  |  |
| Serum Testosterone |  |  |
| **Male** |
| Semen Analysis: (if abnormal repeat in 6 weeks) |
| Count |  |
| Motility |  |
| Morphology |  |

* **Assess and manage ovulation disorders appropriately and consider referral to secondary care at this stage**
* **Refer to secondary care for further investigations for suspected uterine and tubal abnormalities**
* **Refer for unexplained infertility if all hormonal profile and semen analysis normal**

**Other investigations (if previous result available):**

|  |  |  |
| --- | --- | --- |
| **Investigations** | **Date** | **Results** |
| Tubal Surgery |  |  |
| Laparoscopy & Dye  |  |  |
| Hysteroscopy  |  |  |
| Hysterosalpingogram  |  |  |
| Ultrasound |  |  |

**Screening tests:**

|  |
| --- |
| **Screening** |
| **Test** | **Female** | **Male** |
| **Date** | **Result** | **Date** | **Result** |
| Chlamydia Screening |  |  |  |  |
| Rubella |  |  |  |  |
| Cervical Smear |  |  |  |  |

**Pregnancy history/child**:

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| --- |
| Comments i.e. previous pregnancy incl outcomes, child, adoption  |
| Female |  |
| Male |  |

**Referred by:**

|  |  |
| --- | --- |
| Signed: | Date: |
| Print Name: |