**REFERRAL CRITERIA**

* **A Fertility Pathway Guide is available via Saint Mary’s website (Services section):** [**https://mft.nhs.uk/saint-marys/**](https://mft.nhs.uk/saint-marys/)
* **Please ask patients to complete the “Registration Questionnaire – Dept. of Reproductive Medicine” available via the Referral Forms section of Saint Mary’s website and post asap (see link above)**
* **Please refer women who have been trying to become pregnant:**
	+ for more than **one year** if aged **less than 36 years**
	+ for more than **6 months** if aged **36 years or more**

**unless there is an ‘obvious’ cause (e.g. irregular cycles, history of PID, endometriosis, suboptimal semen analysis), in which case please refer straightaway**

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| For any queries, please call 0161 276 6000, Option 7 (Mon-Fri 8.30-16:30)**Please ensure this form is fully completed plus any relevant additional information** **and refer via eReferral** |

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| **PATIENT DETAILS** | **GP DETAILS** |
| **Name** | Title  | Given Name  | Surname  | **GP Name**  | Usual GP Full Name  |
| **DOB** | Date of Birth **Age:** Age | **GP GMC No.** | Usual GP GMC Number  |
| **Address** | Home Full Address (single line)  | **Name of Referrer** |       |
| **Tel No**  | Home: Patient Home Telephone Mobile: Patient Mobile Telephone  | **Surgery** | Organisation Name Organisation Full Address (single line)  |
| **NHS No.** | NHS Number  | **Practice code** | Organisation National Practice Code  |
| **Email Address** | Patient E-mail Address       | **Tel** | Organisation Telephone Number  |
| **Ethnicity** | Ethnic Origin  | **Fax** | Organisation Fax Number  |
| **Religion** | Religion  | **Referral date** | Short date letter merged       |
| **Next of Kin** | Single Code Entry: Patient's next of kin  |  |  |
| **Interpreter required?** | Yes [ ]  No [ ] If Yes, which language?       |  |  |

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| **History of infertility as a couple:** |
| Primary | [ ]  |
| Secondary | [ ]  |
| Duration trying to conceive |       |

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| **Important additional information** |
| Female body mass index (>30 advise weight loss) |       |
| Any known Gynae condition (please specify) |       |
| Please ensure folic acid and vitamin D started | Yes [ ]  No [ ]  |
| Folic acid and Vitamin D started | Yes [ ]  No [ ]  |
| Cervix smear up to date | Yes [ ]  No [ ]  |
| Please ensure patient has had MMR jab or is Rubella immune on testing | Yes [ ]  No [ ]  |
| Chlamydia Result |       |
| Smoker / using e-cigarettes – advice given |       |
| **Patient has been given Reproductive Medicine Questionnaire to send to Saint Mary’s. Please note that appointment will not be made unless this is received** | Yes [ ]  No [ ]  |

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| **PARTNER’S DETAILS** |
| **Name** |       |        |        |
| **DOB** |        |
| **Address** |       |
| **Tel No**  | Home:       Mobile:       |
| **NHS No.** |       |

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| **Additional information** (including any medical problems) |
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| **HEALTH PROFILE** |

Height

Weight

BMI

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| **Last 5 BPs** |

Blood Pressure

Family History

Allergies

Single Code Entry: H/O: non-drug allergy

Problems

Medication

Values and Investigations

Radiology