**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