**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/)
* **Patients will be asked to complete a Registration Questionnaire - please note that an appointment will not be made unless this is received.**
* **Please refer women who have been trying to conceive:**
	+ 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.**

* **Chlamydia test within the last 6 months.**
* **FSH, LH & TFT is not required.**

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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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| **PARTNER’S DETAILS** |
| **Name** |       |        |        |
| **DOB** |       |

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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) |       (read code result and date here xx) |
| Any known Gynae condition (please specify) |       |
| Folic acid and vitamin D (400mcg) advised | Yes [ ]  No [ ]  |
| Cervix smear up to date | Yes [ ]  No [ ]       (read code result and date here xx) |
| Please check patient has had 2 x doses of MMR and if not, arrange rubella antibody testing and vaccinate if not immune | Yes [ ]  No [ ]  |
| Chlamydia test within the last 6 months |       (read code result and date here xx) |
| Smoker / using e-cigarettes – cessation advice given (n.b. smokers are not eligible for IVF treatment)  | Yes [ ]  No [ ]       (cessation advice given read code result and date here xx) |

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| **Additional information** |
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| **HEALTH PROFILE** |

Height

Weight

BMI

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| **Last 2 BPs** |

Blood Pressure

Family History

Allergies

Problems

Medication

Values and Investigations

Radiology

Only significant problems