**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 35 years**
  + for more than **6 months** if aged **35 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.**

* **Semen analysis within the last 6 months (if recently requested please ask patient to bring result to clinic)**
* **Chlamydia test within the last 6 months.**
* **AMH, 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) | Single Code Entry: Body mass index |
| Any known Gynae condition (please specify) |  |
| Folic acid and vitamin D (400mcg) advised | Yes  No |
| Cervix smear up to date | Yes  No  Single Code Entry: Cervical smear result... |
| 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 | Single Code Entry: Chlamydia antigen test... |
| Semen analysis within the last 6 months | Single Code Entry: Semen analysis |
| Smoker / using e-cigarettes – cessation advice given (n.b. smokers are not eligible for IVF treatment) | Yes  No  Single Code Entry: Smoking cessation advice |

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| **Additional information** |
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| **HEALTH PROFILE** | | |
| Height | Single Code Entry: Standing height | |
| Weight | Single Code Entry: Body weight | |

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| **Last 2 BPs** |

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| Blood Pressure | Blood Pressure |
| Family History | Family History |
| Problems | Problems |
| Medication | Medication |
| Radiology | Radiology |
| Investigations | Investigations |

Only significant problems