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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: | Mr |  | Mrs | |  | Miss |  | Ms |  | | | Dr |  | Other (please specify): | | |  | |
| Surname/Last name: | | | |  | | | | | | | | Forename/First name(s): | | | |  | | |
| Previous Name or Name at birth if different from current surname: | | | | | | | | | | | | | | |  | | | |
| State gender (if you wish to): | | | | | | | | | | |  | | | | | | | |
| Are you married/ in a civil partnership with the person you are being treated with? | | | | | | | | | | | | | | | | | |  |
| If **NO**, please state your relationship: | | | | | | | | | |  | | | | | | | | |
| Are you married/ in a civil partnership with any other person you are being treated with? | | | | | | | | | | | | | | | | | |  |
| If **YES**, please state their name: | | | | | | | | | | | |  | | | | | | |

**PATIENT**

|  |  |
| --- | --- |
| Telephone No. (Home): |  |
| Telephone No. (Work): |  |
| Telephone No. (Mobile): |  |
| Email: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Occupation: | | |  | | | Date of Birth: | |  | | | Age: |  |
| Address: |  | | | | | | | | | | | |
| Post Code: | |  | | | | | | | | | | |
| Religion: |  | | | | | | Ethnicity: | |  | | | |
| Town and Country of Birth: | | | | |  | | | | | | | |
| Do you have the right to live and work in the UK? | | | | | | | | | |  | | |
| Can you show that you have the right to receive NHS treatment free of charge? | | | | | | | | | |  | | |
| Type of Visa: | | | |  | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: | Mr |  | Mrs | |  | Miss |  | Ms |  | | | Dr |  | Other (please specify): | | |  | |
| Surname/Last name: | | | |  | | | | | | | | Forename/First name(s): | | | |  | | |
| Previous Name or Name at birth if different from current surname: | | | | | | | | | | | | | | |  | | | |
| State gender (if you wish to): | | | | | | | | | | |  | | | | | | | |
| Are you married/ in a civil partnership with the person you are being treated with? | | | | | | | | | | | | | | | | | |  |
| If **NO**, please state your relationship: | | | | | | | | | |  | | | | | | | | |
| Are you married/ in a civil partnership with any other person you are being treated with? | | | | | | | | | | | | | | | | | |  |
| If **YES**, please state their name: | | | | | | | | | | | |  | | | | | | |

**PARTNER**

|  |  |
| --- | --- |
| Telephone No. (Home): |  |
| Telephone No. (Work): |  |
| Telephone No. (Mobile): |  |
| Email: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Occupation: | | |  | | | Date of Birth: | |  | | | Age: |  |
| Address: |  | | | | | | | | | | | |
| Post Code: | |  | | | | | | | | | | |
| Religion: |  | | | | | | Ethnicity: | |  | | | |
| Town and Country of Birth: | | | | |  | | | | | | | |
| Do you have the right to live and work in the UK? | | | | | | | | | |  | | |
| Can you show that you have the right to receive NHS treatment free of charge? | | | | | | | | | |  | | |
| Type of Visa: | | | |  | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Weight: |  | | | | | Patient Height: | | | | |  | | |
| **If your BMI (Body Mass Index) is below 19 or above 30 this may affect your fertility and your eligibility for treatment** | | | | | | | | | | | | | |
| Do you smoke? (**Patient**) | |  | | | | | Do you smoke? (**Partner**) | | | | | |  |
| **Smoking can affect your fertility; therefore we advise that both patient and partner stop smoking. The CCG will not fund NHS assisted conception treatment if you smoke** | | | | | | | | | | | | | |
| Have you ever had IVF treatment- either NHS or Self-Funded? | | | | | | | |  | | | | | |
| If **YES**, how many treatment cycles have you had? | | | NHS |  | | | | | | Self-Funded | |  | |
| If **YES**, did you have IVF treatment at St. Mary’s Hospital | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | |
| Have you ever had IUI treatment- either NHS or Self-Funded? | | | | | | | |  | | | | | |
| If **YES**, how many treatment cycles have you had in a fertility clinic? (**Home inseminations are not counted**) | | | NHS | |  | | | | Self-Funded | | |  | |
| If **YES**, did you have IUI treatment at St. Mary’s Hospital | | | | | | | |  | | | | | |
| **If you have had IVF/IUI before please obtain a copy of your notes and bring them to your appointment (if not treated at Saint Mary’s Hospital)** | | | | | | | | | | | | | |

**INFORMATION REQUIRED TO ASSESS ELIGIBILITY**

All patients please complete this section to ensure your treatment is not delayed

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How long have you lived together? | |  | | | |
| How long have you been trying for a baby in this relationship? | | | |  | |
| **Patient** | | | **Partner** | | |
| Do you have any children (including adopted)? |  | | Do you have any children (including adopted)? | |  |
| Have you had any previous Sterilisation/ Vasectomy? |  | | Have you had any previous Sterilisation/ Vasectomy? | |  |
| Have you been given a diagnosis? | | |  | | |
| If **YES**, please specify | | |  | | |
| Female Patient- Have you had 2 doses of MMR Vaccine | | |  | | |
| **If the answer is no or you are unsure, please see your GP to arrange MMR Vaccine** | | | | | |

**Female Patient: Please ensure that you are up to date with your cervical smears**

**INFORMATION REQUIRED TO ASSESS ELIGIBILITY**

All patients please complete this section to ensure your treatment is not delayed

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the patient and partner understand and speak English? | | |  | |
| If you have answered **NO**, what is your spoken language | |  | | |
| Signed (Patient): |  | Signed (Partner): | |  |
| Date: |  | Date: | |  |

|  |  |
| --- | --- |
| **IT IS IMPORTANT THAT YOU RETURN THIS QUESTIONNAIRE WITHIN 14 DAYS TO THE ADDRESS BELOW OTHERWISE WE WILL PRESUME YOU ARE NOT GOING TO PURSUE TREATMENT AND YOU WILL BE DISCHARGED BACK TO YOUR REFERRING DOCTOR.** | |
| By E-MAIL: **IVF.PatientQuestionnaire@cmft.nhs.uk** | |
| By POST: | **Department of Reproductive Medicine**  **Old Saint Mary’s Hospital**  **Oxford Road**  **Manchester**  **M13 9WL** |
| **PLEASE INFORM US IF ANY OF YOUR DETAILS ABOVE CHANGE, FOR EXAMPLE: YOUR MARITAL STATUS, YOUR GENDER, YOUR ADDRESS. THIS IS FOR REGISTRATION PURPOSES AND TO ENSURE YOU RECEIVE OUR CORRESPONDENCE** | |
| Telephone: **0161 276 6000** | |

**PATIENT: ETHNICITY & RELIGION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ethnicity** (Please tick which ethnic group you feel you belong) | | | | | | | | | | | |
| **European White** | | | | **Black or Black British** | | | | **Other Ethnic Groups** | | | |
| A. |  | British White | | M. |  | Caribbean (Black or Black British) | | R. |  | Chinese (Other Ethnic Groups) | |
| B. |  | Irish White | | N. |  | African (Black or Black British) | | S. |  | Any other Ethnic Groups | |
| C. |  | Other White Background | | P. |  | Other Black Background | |  | | | |
| Please specify | | |  | Please specify | | |  | Please specify | | |  |
|  | | | | | | | | | | | |
| **Mixed** | | | | **Asian** | | | |  | | | |
| D. |  | White / Black Caribbean | | H. |  | Indian (Asian or Asian British) | | Z. |  | I do not wish to specify my Ethnic group | |
| E. |  | White / Black African | | J. |  | Pakistani (Asian or Asian British) | |  | | | |
| F. |  | White / Asian | | K. |  | Bangladeshi (Asian or Asian British) | |
| G. |  | Other Mixed Background | | L. |  | Other Asian Background | |
| Please specify | | |  | Please specify | | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Religion** (Please tick the religion that applies to you) | | | | | |
| Anglican |  | Church of Scotland |  | Other |  |
| Agnosic |  | Church in Wales |  | Pagan |  |
| Atheist |  | Don’t want to answer |  | Plymouth Brethren |  |
| Baptist |  | Hindu |  | Pentecostal |  |
| Bahia |  | Islam |  | Presbyterian |  |
| Buddhist |  | Jewish |  | Protestant |  |
| Catholic |  | Jain |  | Quaker |  |
| Church of England |  | Jehovah’s Witness |  | Roman Catholic |  |
| Church of God |  | Moravian |  | Salvation Army |  |
| Other Christians |  | Methodist |  | Seventh Day Adventist |  |
| Christadelphian |  | Mormons |  | Sikh |  |
| Church of Ireland |  | Muslim |  | Unitarian |  |
| Church of Living God |  | No Religion |  | United Reform Church |  |
| Congregational |  | Orthodox |  | Zoroastrian |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ethnicity** (Please tick which ethnic group you feel you belong) | | | | | | | | | | | |
| **European White** | | | | **Black or Black British** | | | | **Other Ethnic Groups** | | | |
| A. |  | British White | | M. |  | Caribbean (Black or Black British)  **PARTNER: ETHNICITY & RELIGION FORM** | | R. |  | Chinese (Other Ethnic Groups) | |
| B. |  | Irish White | | N. |  | African (Black or Black British) | | S. |  | Any other Ethnic Groups | |
| C. |  | Other White Background | | P. |  | Other Black Background | |  | | | |
| Please specify | | |  | Please specify | | |  | Please specify | | |  |
|  | | | | | | | | | | | |
| **Mixed** | | | | **Asian** | | | |  | | | |
| D. |  | White / Black Caribbean | | H. |  | Indian (Asian or Asian British) | | Z. |  | I do not wish to specify my Ethnic group | |
| E. |  | White / Black African | | J. |  | Pakistani (Asian or Asian British) | |  | | | |
| F. |  | White / Asian | | K. |  | Bangladeshi (Asian or Asian British) | |
| G. |  | Other Mixed Background | | L. |  | Other Asian Background | |
| Please specify | | |  | Please specify | | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Religion** (Please tick the religion that applies to you) | | | | | |
| Anglican |  | Church of Scotland |  | Other |  |
| Agnosic |  | Church in Wales |  | Pagan |  |
| Atheist |  | Don’t want to answer |  | Plymouth Brethren |  |
| Baptist |  | Hindu |  | Pentecostal |  |
| Bahia |  | Islam |  | Presbyterian |  |
| Buddhist |  | Jewish |  | Protestant |  |
| Catholic |  | Jain |  | Quaker |  |
| Church of England |  | Jehovah’s Witness |  | Roman Catholic |  |
| Church of God |  | Moravian |  | Salvation Army |  |
| Other Christians |  | Methodist |  | Seventh Day Adventist |  |
| Christadelphian |  | Mormons |  | Sikh |  |
| Church of Ireland |  | Muslim |  | Unitarian |  |
| Church of Living God |  | No Religion |  | United Reform Church |  |
| Congregational |  | Orthodox |  | Zoroastrian |  |