Registration Questionnaire – Department of Reproductive Medicine

NHS
Manchester University
NHS Foundation Trust

Department of Reproductive Medicine
Old Saint Mary's Hospital Oxford Road
M13 9WL
Telephone 0161 276 6000

PATIENT

Mr/Mrs/Miss/Ms/Dr/Other | **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? Yes / No. If NO please state your relationship. | **NHS number (Please ask your GP if you do not know)**

Are you married / in a civil partnership with any other person than the person you are being treated with? Yes/ No. If so, please state their name.

Occupation | **Date of Birth** | **Age**

Address | **Post Code**

Religion | **Ethnicity** | **Town and Country of Birth**

Have you been living legally in the UK for the last 12 months? Yes / No | **Can you show that you have the right to receive NHS treatment free of charge? Yes / No** | **Type of Visa**

Telephone No. Home | **Telephone No. Work** | **Telephone No. Mobile**

Email

GP Name and Address

Please attach a passport sized photograph. The reason we request a photograph is HFEA (Human Fertilisation and Embryology Authority) requires centres to have a thorough process for identifying patients for a number of licensed treatments. If you do not wish to provide these at this stage you will be required to bring these at your new patient IVF appointment

PARTNER

Mr/Mrs/Miss/Ms/Dr/Other | **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? Yes / No. If NO please state your relationship. | **NHS number (Please ask your GP if you do not know)**

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INFORMATION REQUIRED TO ASSESS ELIGIBILITY

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

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? Yes / No

If Yes, how many IVF treatment cycles have you had either NHS or self-funded?

Self-Funded: **NHS:**

Have you ever had IUI treatment either NHS or self-funded? Yes / No

If yes how many IUI treatment cycles have you had in a fertility clinic (home inseminations are not counted)?

Self-Funded: **NHS:**

If yes, did you have IVF treatment as Saint Mary's Hospital? Yes / No

If Yes, did you have IUI treatment at Saint Mary's Hospital? Yes / No

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)

How long have you lived together?

How long have you been trying for a baby in this relationship?

(Patient) Do you have any children (including adopted)?

Partner)) Do you have any children (including adopted)?

(Patient) Have you had previous Sterilisation/ Vasectomy?

(Partner) Have you had previous Sterilisation/ Vasectomy?

Have you been given a diagnosis? Yes / No

If yes, please specify

Female patient – Have you had 2 doses of MMR Vaccine? Yes / No

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.

IF YOU HAVE HAD ANY PREVIOUS INVESTIGATIONS, PLEASE BRING COPIES OF THE RESULTS TO YOUR APPOINTMENT AS WE ARE NOT ABLE TO ACCESS YOUR INVESTIGATIONS

Do the patient and partner understand and speak English? Yes / No

If you have answered No, what is your spoken language?

Signed Patient	**Signed Partner**

Date :

PLEASE COMPLETE ALL QUESTIONS AND ATTACH RECENT PASSPORT TYPE PHOTOGRAPHS

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.

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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.