## **Registration Questionnaire – Department of Reproductive Medicine**



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

PATIENT				
Mr/Mrs/Miss/Ms/Dr/Other Sur	Surname/Last name		Forename/First name(s)	
Previous Name or Name at Birth if different from	vious 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 state their name.	other person than the	person you are be	ing treated with? Yes/ No. If so, please	
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** 

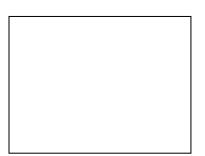
Please attach a passport sized photograph. The reason we request a photograph is HFEA (Human Fertilisation and Embryology Authority) requires centres to have a thorough process for identifying patients for a number of licensed treatments. If you do not wish to provide these at this stage you will be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

## PARTNER

Mr/Mrs/Miss/Ms/Dr/Other S	Surname/Last name	rname/Last name Forename/First na				
Previous Name or Name at Birth if different fro	ne 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 tha right to receive NH free of charge? Ye	IS treatment	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



## **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 m Do you smoke? (Patient)	ay affect your fertility and your eligibility for treatment Do you smoke? (Partner)		
Smoking can affect your fertility; therefore we advise that bot assisted conception treatment if you smoke	th patient and partner stop smoking. The CCG will not fund NHS		
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 no Mary's Hospital)	otes and bring them to your appointment (if not treated at Saint		
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 WI 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.

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.