**Referral Form for Infertility Assessment Only – CRITERIA BASED ACCESS**

**Patients from the BNSSG Integrated Care Board area only**

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| **Patient 1 Name** |  |  Male |  [ ]  | Female |  [ ]  |
| **Address** **Post Code**  |   |
| **Date of Birth** |  | **NHS Number** |  |
| **Patient 2 Name** |  |  Male |  [ ]  | Female |  [ ]  |
| **Address****Post Code**  |  |
| **Date of Birth** |  | **NHS Number** |  |
| **Criteria for Referral for Assessment by Fertility Services** The Access to Infertility Assessment and Treatments Policy is available on the relevant ICB website.For heterosexual and same sex couples, If either partner has living offspring, the couple is not able to access NHS fertility services including assessmentFor single women, if they have living offspring, they are not able to access NHS fertility services including assessmentPlease note:* Recurrent miscarriage is not an indication for patients to access Fertility Services although, if appropriate, patients may be referred for gynaecological investigations rather than fertility services and treatments.
* Prospective fathers with a BMI of over 29.9 kg/m2 should be offered a referral to weight management services to reduce their weight, as obesity can impact on fertility.
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| 1.a | For couples in a heterosexual relationship – Has the couple failed to conceive after regular unprotected sexual intercourse for two years? | YesNo N/A  | [ ] [ ] [ ]  |
| 1.b | For same sex couples – Has insemination on at least 6 cycles at an HFEA licenced centre, over a period of 2 years, failed to lead to a pregnancy? | YesNo N/A | [ ] [ ] [ ]  |
| 1.c | For single women – has the prospective mother failed to conceive after two years of regular unprotected sexual intercourse or after 6 independently funded non-stimulated cycles of IUI from an HFEA approved source? | YesNo NA | [ ] [ ] [ ]  |
| 1.d | Is there a known condition likely to effect the fertility of either the individual or, if applicable, their partner, for example:* severe oligomenorrhoea
* bilaterally blocked fallopian tubes,
* stage 4 endometriosis
* premature or known ovarian failure
* there is a sexual health condition where the patient is unable to have penetrative sex
 | YesNo NA | [ ] [ ] [ ]  |
| 2. | Is the prospective mother aged less than her 39th birthday at the time of referral?  | YesNo | [ ] [ ]  |
| 3. | Is the prospective father aged less than his 54th birthday at time of referral? | YesNo N/A | [ ] [ ] [ ]  |
| 4. | Has the individual or partner if applicable, previously been sterilised, even if it has subsequently been reversed? | YesNo | [ ] [ ]  |
| 5. | Are both partners are non-smokers? | YesNo | [ ] [ ]  |
| 6.a | Has the prospective mother’s BMI been between 19 and 29.9 kg/m2 for a period of six months and is this documented in her Primary Care records?**Please note that patients with a BMI of 30 kg/m2 or above should be offered a referral to weight management services to reduce their weight, prior to assessment and treatment by Fertility Services.** | YesNo N/A | [ ] [ ] [ ]  |
| 6.b | Is the prospective mother aged between 37 and 38th birthday, 34 weeks and her BMI is between 30 and 35 kg/m2 and shehas been referred to weight management services **at the same time as being referred to fertility services, in order assist her to lose weight and aid fertility**. | YesNo N/A | [ ] [ ] [ ]  |
| 7. | Is the individual being assessed and their partner if applicable, registered with a GP in the BNSSG area? | YesNo | [ ] [ ]  |
| 8. | For same sex couples - Has the possibility of the other partner trying to conceive before proceeding to interventions involving the sub-fertile partner been discussed and rejected? | YesNo N/A | [ ] [ ] [ ]  |
| 9. | Does the individual requiring assessment and, if in a relationship, their partner have any living or adopted children?  | YesNo | [ ] [ ]  |
| 10. | Have any of the individuals involved previously received an NHS funded cycle of fertility treatment, whether successful of not? | YesNo | [ ] [ ]  |

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| **I am the registered GP of:** The prospective mother:  **[ ]**  The partner:  **[ ]**  Both: **[ ]** Where you are not the registered GP of both patients, please ensure that the GP of the partner registered elsewhere is aware of this referral as they may need to supply clinical data to Fertility Services.Where appropriate, please refer to the website of the service you are referring your patients to, so that you are aware of the information that should be supplied by letter with this referral. The website of Bristol Centre for Reproductive Medicine is available here: <http://www.nbt.nhs.uk/bcrm/referral-and-costs/nhs-referrals> **Please confirm:** **[ ]** I recommend proceeding to an assessment by Fertility Services for this couple. **[ ]** I have informed the patients that this intervention is only funded where criteria are met. **[ ]** The couple are aware of the limits of treatments offered under the NHS under this care pathway. **[ ]** I have included a covering letter summarising the clinical history of my patient / both my patients. |

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| **Signed:** |  | **Date:** |  |
| **Name:** |  | **Practice Address:** |   |
| This form should now be sent to the service you are referring your patients to. In order to access assisted conception services following investigation and assessment, couples will also be assessed against the following criteria. Please ensure your patients are informed of these criteria prior to referral and the couple are aware that this referral may **not** lead to fertility treatment:**For Assisted Conception**

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| The BMI of the prospective mother must remain between 19 and 29.9 kg/m2 whilst accessing fertility treatment. This is because the success of fertility treatment is significantly reduced where the prospective mother is outside of these limits. |
| Account will be taken of additional factors such as active hepatitis, alcoholism, intra-venous drug misuse that may adversely affect the welfare of any child born as a result of treatment or give rise to complex treatment issues. |
| The male partner must have normal sperm function (except for ICSI, donor sperm or surgical sperm recovery). |
| The prospective mother must havea. an AMH of greater than or equal to 5.4 pmol/l **OR** b. a FSH level less than or equal to 15iu/l. |
| If donor sperm / oocytes are used the couple must be able to demonstrate in writing joint legal responsibility for any child born as a result of treatment. |

**For IVF or ICSI**

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| The prospective mother’s serum FSH must be less than or equal to 12iu/l at the time of treatment **AND / OR** an AMH of greater than or equal to 5.4 pmol/l. |
| The prospective father’s serum FSH level must be less than 15 iu/l or testicular volume must be greater than 8ml (as assessed by a fertility specialist) for surgical sperm recovery and storage to be undertaken. |

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**Trust Requirement - Preliminary Investigations**

**Hard copies of the test results need to be attached.**

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| **Female** |
|  | **Attached** |
| Hepatitis B surface antigen | YesNo | [ ] [ ]  |
| Hepatitis B core antibody | YesNo | [ ] [ ]  |
| Hepatitis C serology | YesNo | [ ] [ ]  |
| HIV Screening | YesNo | [ ] [ ]  |
| Syphilis | YesNo | [ ] [ ]  |
| Rubella | YesNo | [ ] [ ]  |
| Chlamydia | YesNo | [ ] [ ]  |
| serology Serum LH (Up to Day 4 of menstrual cycle) | YesNo | [ ] [ ]  |
| Serum FSH (Up to Day 4 of menstrual cycle) | YesNo | [ ] [ ]  |
| Serum Estradiol (E2) (Up to Day 4 of menstrual cycle) | YesNo | [ ] [ ]  |
| Serum Testosterone | YesNo | [ ] [ ]  |
| Serum TSH | YesNo | [ ] [ ]  |
| Hb/basic haematology | YesNo | [ ] [ ]  |
| Haemoglobinopathy screen by Hb electrophoresis (if non-Caucasian) | YesNo | [ ] [ ]  |

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| **Male** |
|  | **Attached** |
| Hepatitis B surface antigen | YesNo | [ ] [ ]  |
| Hepatitis B core antibody | YesNo | [ ] [ ]  |
| Hepatitis C serology | YesNo | [ ] [ ]  |
| HIV Screening | YesNo | [ ] [ ]  |
| Syphilis | YesNo | [ ] [ ]  |
| Semen analysis – one test is adequate if normal. A second test is required if the first is abnormal which should be at least 3 months later. | YesNo | [ ] [ ]  |