**King’s Fertility Referral Form**

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| --- | --- |
| **Referral Date:** |  |
| **Referrer’s Name:** |  |
| **CCG:** |  |
| **NHS or Self-Funding** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | NHS Number: | |
| Title: |  | Surname: |  |
| Address: |  | First Name: |  |
|  |  | Date of Birth: |  |
|  |  | Town of Birth: |  |
|  |  | Country of Birth |  |
| Can we contact patient by email Y/N | | Ethnicity: |  |
| Email: | | Home Tel. No. |  |
| Work Tel. No. | | Mob. Tel. No |  |
| Height cm | | Interpreter | Y/N |
| Weight Kg | | Language: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Partner Details** | | NHS Number: | |
| Title: |  | Surname: |  |
| Address: |  | First Name: |  |
|  |  | Date of Birth: |  |
|  |  | Town of Birth: |  |
|  |  | Country of Birth |  |
| Can we contact partner by email Y/N | | Ethnicity: |  |
| Email: | | Home Tel. No. |  |
| Work Tel. No. | | Mob. Tel. No |  |
| Height cm | | Interpreter | Y/N |
| Weight Kg | | Language: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Details** | | | |
| GP NAME: |  | Address: |  |
| SURGERY: |  |  |  |
|  |  |  |  |
| Tel No: |  |  |  |
| Fax No: |  | Postcode: |  |

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| --- |
| **NHS Eligibility Criteria** |

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| --- |
| Time trying to conceive together (months): |

|  |  |  |
| --- | --- | --- |
| **Other Criteria** | **Patient** | **Partner** |
| Existing children (number) |  |  |
| Sterilised Yes/No |  |  |
| Smoker Yes/No |  |  |

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| --- |
| **Previous Fertility Treatments And Investigations** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Hospital | Treatment | Funding | Outcome |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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| --- | --- | --- | --- |
| **Clinical Record** | | | |
| Cause of infertility (if identified): | | (or) Years of unexplained infertility: | |
| **Investigations** (if carried out) | **Date** | | **Result** |
| FSH on Day 2 – 5 |  | |  |
| LH on Day 2 – 5 |  | |  |
| Oestradiol on Day 2 – 5 |  | |  |
| Mid-luteal Progesterone |  | |  |
| Semen Analysis |  | |  |
| TSH |  | |  |
| Rubella immunity |  | |  |
| Haemoglobinopathy screen  (if relevant) |  | |  |
| Other: |  | |  |
|  |  | |  |
|  |  | |  |

**Does this couple meet the local Clinical Commissioning Group (CCG) criteria for IVF/ICSI NHS funding:** **YES / NO**

**Declaration by referrer**:

The information I have provided on this form is correct to the best of my knowledge

Name: Date:

For **NHS** referrals please send form to: [NHSreferrals@kingsfertility.co.uk](mailto:NHSreferrals@kingsfertility.co.uk)

For **private** referrals please send form to: [referrals@kingsfertility.co.uk](mailto:referrals@kingsfertility.co.uk)