**Tertiary Fertility Services**

**Prior Approval form**

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| **Patient Consent** *Tick**as appropriate* | **Yes** | **No** |
| Is the patient aware of this referral and the content of this form? | [ ]    | [ ]    |
| By submitting this request, you are confirming that you have fully explained to the patient why they are eligible for NHS treatment, and they have consented to you submitting this referral. |

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| **Referrals to fertility specialist services must be made by the secondary care provider following prerequisite investigations or treatments required, which may be undertaken at either the primary level or secondary level as appropriate****Once fully completed please submit this form to the following email address:** mseicb.ifrfunding@nhs.net |

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| **Patient Information** |
| **Name:** | Click here to enter text. |
| **Address:** | Click here to enter text. | **DOB:** | Click here to enter a date. |
| **NHS No:** | Click here to enter text. |
| **Home Tel No:** | Click here to enter text. |
| **Mobile Tel No:** | Click here to enter text. |

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| **Partner Information** |
| **Name:** | Click here to enter text. |
| **Address:** | Click here to enter text. | **DOB:** | Click here to enter a date. |
| **NHS No:** | Click here to enter text. |
| **Home Tel No:** | Click here to enter text. |
| **Mobile Tel No:** | Click here to enter text. |

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| **GP Information** |
| **Name:** | Click here to enter text. |
| **Address:** | Click here to enter text. | **GP F-code**Click here to enter text. | **Telephone No:** Click here to enter text. |
| **NHS net email address:** |
| Click here to enter text. |

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| **Date of Initial GP Referral:** | Click here to enter a date. |

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| **Name of Referring Consultant** | Click here to enter text. | **Telephone number:** | Click here to enter text. |
| **Hospital of Referring Consultant:** | Click here to enter text. |
| **Hospital/Hospital number**  | Click here to enter text. |

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| **Date of Consultant Referral:** | Click here to enter a date. |

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| **Criteria** | **Response** | **Eligible***(tick as appropriate* |
|  |  | **Yes** | **No** |
| **Duration of infertility:** | Years: | Click here to enter text. | [ ]    |[ ]
| **Diagnosed cause of absolute infertility** **(**please state) | State: | Click here to enter text. | [ ]    |[ ]
| **At least 2 years infertility** (2 years of ovulatory cycles) **despite regular unprotected vaginal sexual intercourse with the partner seeking treatment or a diagnosed cause of absolute infertility:** | State: | Click here to enter text. | [ ]    |[ ]
| **Previous IVF/IUI cycles** (whether self or NHS funded) | Number: | Click here to enter text. | [ ]    |[ ]
| **Age of female at date of referral to IVF provider service** (policy states 23 to 42 and 364 days of age) | Years: | Click here to enter text. | [ ]    |[ ]
| **BMI of female at date of referral to IVF provider service** (policy states more than 19kg/m2 and less than 30kg/m2) | BMI: | Click here to enter text. | [ ]    |[ ]
| **BMI of male at date of referral to IVF provider service** (policy states less than 35kg/m2) | BMI: | Click here to enter text. | [ ]    |[ ]
| **FSH level on day 2 of cycle within 3 months**: (policy states less than 9) | Level Click here to enter text. | Date FSH completedClick here to enter a date. | [ ]    | [ ]    |
| **Both individuals in the couple must be ordinarily resident in the UK and have been registered with a GP within Mid and South Essex ICB for a minimum of 12 months** | Yes/no | [ ]   **Yes**  [ ]  **No**   |  |  |
| **Not eligible if answer ‘yes’ to any of these questions:** |
| **Do either of the couple smoke?**(Please note couples must be non-smokers at the time of treatment). | **Yes:** | [ ]    | **No:** | [ ]   |  |  |
| **Living Children*** There should be no surviving children from this relationship including adopted children but excluding fostered children.
 | **Yes:** | [ ]    | **No:** | [ ]   |  |  |
| * There should be no children from previous relationships
 | **Yes:** | [ ]    | **No:** | [ ]   |  |  |
| **Have either partner been sterilised?**  | **Yes**: | [ ]    | **No:** | [ ]   |  |  |

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| **In an interpreter required?** | **Yes** | **No** | If ‘Yes’ what language (including sign language) | Click here to enter text. |
| [ ]     | [ ]    |

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| **Procedure/treatment required** | **Please complete as required** |
| **IVF with or without ICSI (Standard package will include)*** Initial consultant, follow up consultant, and counselling session.
* All ultrasound scan and hormone assessment during the treatment cycle
* Oocyte stimulation
* Oocyte recovery – by vagina ultrasound guided aspiration under sedation or local anaesthesia: laparoscopy as appropriate under general anaesthesia
* IVF or ICSI to produce embryos and blastocyst culture as appropriate
* Embryo, or blastocyst transfer, into uterine cavity.
* Pregnancy test and max two scans to establish pregnancy viability
* Drug costs and sperm preparation
 |  [ ]    |
| **Embryo/blastocyst freezing and storage**Commissioned as part of the service requirement, and will be funded for up to 12 months following completion of NHS Treatment |  [ ]    |
| **Surgical sperm recovery** (TESA/PESA including storage where required)Will be funded for up to 12 months following completion of NHS Treatment |  [ ]     |
| **Donor oocyte cycle**For individual with embryo/blastocyst stored |  [ ]    |
| **Donor Sperm insemination** |  [ ]    |
| **Egg and sperm storage for patients undergoing cancer treatments**Cryopreserved material may be stored for an initial period of 5 years. (Please see Eligibility Criteria) |  [ ]    |

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| **Provider Choice** *(tick as appropriate)* |
| **Bourn Hall Fertility Clinic - Wickford**25 London RoadWickfordSS12 0AWTel: 01954 717210 / 01268 661700Email: wickfordinfo@bourn-hall.com[www.bournhall.co.uk](http://www.bournhall.co.uk) | [ ]    | **Care Fertility**CARE Fertility LondonPark Lorne111 Park RoadLondon NW8 7JLTel: 0207 6166767<http://www.carefertility.com> | [ ]    |
| **Create Fertility - Wimbledon**St Georges House3-5 Pepys RoadWest Wimbledon SW20 8NJTel: 0203 319 9490<https://www.createfertility.co.uk/> | [ ]    | **Create Fertility – St Paul’s**150 CheapsideLondon EC2V 6ETTel: 0203 319 9490<https://www.createfertility.co.uk/> | [ ]    |
| **Cambridge Hospital**Women’s and Children’s ServicesCambridge University Hospitals NHS Foundation TrustRosie HospitalCambridge Biomedical CampusHills Road. Cambridge, CB2 0QQTel: 01223 217003<http://www.cuh.nhs.uk> | [ ]    | **Guy’s & St Thomas**Guy's and St Thomas’ NHS Foundation Trust11th floor, Tower WingGreat Maze PondLondon SE1 9RT Tel: 020 71882300<http://www.guysandstthomas.nhs.uk> | [ ]    |
| **Herts and Essex Fertility Centre**Bishops CollegeChurchgateChestnutWaltham CrossEN8 9XPTel: 01992 785060<http://www.hertsandessexfertility.com> | [ ]    | **IVI London Wimpole**83 Wimpole StreetLondonW1G 9RQTel: 020 70784868<http://www.ivi.uk> | [ ]    |

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| **Clinical Information** |
| **Number of TOPs:** | Click here to enter text. |
| **Number of miscarriages/ectopics:** | Click here to enter text. |

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| **Investigations Female** |
|  | **Date:** | **Result:** |
| **Ultrasound or pelvic/uterine assessment (specify procedure carried out:** | Click or tap to enter a date. | Click here to enter text. |
| **LH (day 2-4):** | Click or tap to enter a date. | Click here to enter text. |
| **Estradiol (day 2-4):** | Click or tap to enter a date. | Click here to enter text. |
| **Tubal Patency** | Click or tap to enter a date. | Click here to enter text. |

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| **Investigations Male** |
| **Semen Analysis:** | **Date:** | Click or tap to enter a date. | **Volume:** | Click here to enter text. |
| **Sperm Count:** | **Progressively motile:**Click here to enter text. | **Normal forms:**Click here to enter text. |

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| **Sperm storage (if required)** [ ]    |
| **Nature of diagnosis required this procedure:**Click here to enter text. | **Date of diagnosis**Click or tap to enter a date. |
| **Planned treatment/surgery**Click here to enter text. | **Treatment start date:**Click or tap to enter a date. |
| **Please also complete HIV, HEP B/C status**Click here to enter text. |  |

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| **Any other relevant information, e.g. allergies:**Click here to enter text. |

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| **Screening (within last 3 months)** |
| **Test** | **Female** | **Male** |
| **Date** | **Results** | **Date** | **Results** |
| **HIV Screening** | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Hep B Surface Antigen**  | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Hep B Core Antibody** | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Hep C** | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Screening (within last 12 months)** |
| **Test** | **Female** | **Male** |
| **Date** | **Results** | **Date** | **Results** |
| **Chlamydia Screening** | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Haemoglobinopathy Electrophoresis (if indicated** | Click or tap to enter a date. | Click here to enter text. | Click or tap to enter a date. | Click here to enter text. |
| **Rubella**(within the last 5 years) | Click or tap to enter a date. | Click here to enter text. |  |  |
| **Cervical Smear**(within the last 3 years, as per screening pathway) | Click or tap to enter a date. | Click here to enter text. |  |  |

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| **Welfare of the Unborn Child** *Tick as appropriate* | **Yes** | **No** |
| Are you aware of anything in the past medical or social history of either partner, which may be of concern with regards to the welfare of the unborn child? | [ ]    | [ ]    |

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| If the answer is ‘Yes’, but you still wish to refer the couple, please provide full details of any relevant concerns or extenuating circumstancesClick here to enter text. |

**Please include any other relevant blood tests result, investigations or information.**

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| **PLEASE SIGN AND DATE THIS BOX: Funding approval is requested by** |
| **Name of Clinician** | Click here to enter text. |
| **Contact number** | Click here to enter text. |
| **Date** | Click or tap to enter a date. |

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| **FOR ICB COMPLETION ONLY** |
| **DECISION:** Choose an item. |
| **Name** | Click here to enter text. |
| **Signature** | Click here to enter text. |
| **Date** | Click or tap to enter a date. |
| **Reference number** | Click here to enter text. |
| **Number of Cycles****Approved**  | Click here to enter text. |