Aylesbury Vale Clinical Commissioning Group
Bracknell and Ascot Clinical Commissioning Group
Chiltern Clinical Commissioning Group
Newbury and District Clinical Commissioning Group
North and West Reading Clinical Commissioning Group
Oxfordshire Clinical Commissioning Group
South Reading Clinical Commissioning Group
Slough Clinical Commissioning Group
Windsor, Ascot and Maidenhead Clinical Commissioning Group
Wokingham Clinical Commissioning Group

REFERRAL FOR ASSISTED REPRODUCTION SERVICES FOR INFERTILE COUPLES

This form relates to Clinical Commissioning Policy 11g, November 2013

To access treatment for NHS-funded IVF/Assisted Conception treatment, the referring gynaecologist should complete the checklist below and send it with a **referral letter and relevant test results to the provider unit of the patient's choice**. All three sections below must be completed.

NB This form **should not** be used for access to IVF services associated with **pre-implantation genetic diagnosis** or the **preservation of fertility** associated with cancer and other fertility-impairing treatments.

SECTION ONE – CONTACT DETAILS

Name of referring NHS Gynaecologist* (please print): ***All patients must have had a consultation with a NHS gynaecologist***
Name of referring hospital:
Address of referring hospital: **Post code:**
Department's telephone number: **Department's fax number:**

Patient's GP (please print):
GP practice name and address: **Post code:**
Practice telephone number: **Practice fax number:**

FEMALE PATIENT (to undergo IVF treatment)	**PARTNER** **Male / Female**

Name:	**Name:**
Date of birth: **Age:**	**Date of birth:** **Age:**
NHS No: **Patient Reference:**	**NHS No:** **Patient Reference:**
Home Address: **Post Code:**	**Home Address:** **Post Code:**
Tel/Mobile No:	**Tel/Mobile No:**

SECTION TWO – ELIGIBILITY

Policy ref.	Criterion	Yes / No	Eligibility
1	Has the couple gone through the primary and secondary care sub-fertility pathways appropriate to them before IVF is considered? All the following investigations must have been completed prior to referral for assisted conception: semen analysis, rubella, FSH/AMH, Chlamydia, hepatitis B, hepatitis C, HIV **and results sent with referral form to the Provider.**		No = excluded
2	**Age of woman at time of cycle starting*** At the time of commencing treatment will the female be up to 34 years of age inclusive? (ie, before their 35th birthday) *A fresh assisted conception treatment cycle commences either: • at commencement of down regulation OR • the start of ovarian stimulation OR • if no drugs are used, when an attempt is made to collect eggs.		No = excluded
5	**Duration of infertility** a) Does the couple have infertility of > 2 yrs duration? (The couple should have had no natural pregnancies or been using contraception within this timeframe – referring clinician should verify this with GP). **If a) = no then please consider b)**		No to both = excluded
	b) Does the couple have a diagnosed cause of **absolute** permanent infertility (which precludes any possibility of natural conception)? If so, specific details **must** be provided.		
6	**Previous infertility treatment** Has the patient ever received previous IVF or ICSI treatment funded by the NHS?		Yes = excluded
	Has the patient received more than 2 previous cycles of IVF or ICSI (irrespective of whether NHS or privately funded)?		Yes = excluded
12	**Women in same sex couples and couples unable to undertake vaginal intercourse** Is the woman demonstrably sub-fertile? *(6 unsuccessful cycles of IUI will be accepted as evidence of unexplained infertility*)		No = excluded
7	**Childlessness** Does either partner have a living child (including adopted) from their relationship, or from any previous relationship?		Yes = excluded
8	**Sterilisation** Has either partner been sterilised?		Yes= excluded
9	**BMI** Has the female to undergo IVF a BMI of between 19 and 29.9 at the time of referral to your specialist unit?		No = excluded
9	**Smoking** Have both partners been non-smokers for at least the last six months?		No = excluded

SECTION THREE – STATEMENTS CONFIRMING ELIGIBILITY

STATEMENT TO BE SIGNED BY THE REFERRING CONSULTANT

I confirm that all the above access criteria have been met and this person/couple is therefore eligible for NHS funded IVF treatment. They have been advised that, from the below list, they have a choice of Centre for their treatment.

Referrer's name: (please print)

Referrer's signature:

Date of referral:

Designated Centres Please circle as appropriate

1. **Care Fertility**, 67 The Avenue, Northampton, NN1 5BT – 0115 852 8100

2. **Create Fertility St Pauls**, 150 Cheapside, London EC2V 6ET – 0333 240 7300

   Create Fertility Wimbledon, 3-5 Pepys Road, London SW20 8NJ– 0333 240 7300

   Create Fertility Birmingham, Ground Floor, 6270 Bishops Court, Birmingham Business Park, Birmingham B37 7YB– 0333 240 7300

3. **IVI UK**, Midland Fertility Services, Ventura Park Rd, Tamworth, B78 3HL – 0333 015 9774

4. **Oxford Fertility Unit**, Institute of Reproductive Sciences, Oxford Business Park, Oxford OX4 2HW – 01865 782800

5. **Salisbury Fertility Centre**, Salisbury NHS Foundation Trust, Odstock Road, Salisbury, Wilts SP2 8BJ – 01722 417224

6. **University Hospitals Coventry and Warwickshire NHS Trust**, Centre for Reproductive Medicine, University Hospital, Clifford Bridge Road, Coventry CV2 2DX – 024 76968879

*NB The Human Fertilisation and Embryology Authority (HFEA) website has information on **'How to Choose a Fertility Clinic'** and includes information about services and success rates. See:* http://guide.hfea.gov.uk/guide/

STATEMENT TO BE SIGNED BY THE COUPLE

I confirm that I have read and understood the questions above and that the information I have given is correct. I understand that if I knowingly give false information I may be liable to prosecution. I have been advised that I may choose from the above list the Clinic where I/we may receive treatment.

First partner's signature:

Date:

Second partner's signature:

Date:

This form will be returned to the referrer if any of the information requested is incomplete

For use by the tertiary provider/designated centre:

- *Date referral form received:*
- *All necessary information provided?*
- *Patient/couple eligible for treatment?*
- *If 'yes', appointment offered?*
- *If 'no' , date referral sent back to referring specialist*