NHS

Harrogate and Rural District
Clinical Commissioning Group

Appendix 3

REFERRAL FORM FOR ASSISTED CONCEPTION

To access treatment for NHS-funded Assisted Conception treatment, the referring clinician should complete the checklist below. All sections below must be completed.

SECTION ONE – CLINICIAN DETAILS

Referring clinician (GP/consultant):
Referring clinician address: **Post code:** **Contact Telephone Number:**

Patient's GP (if different to referring clinician above):
GP practice name and address: **Post code:**
Practice telephone number: **Practice fax number:**

SECTION TWO – PATIENT DETAILS

FEMALE PATIENT	**PARTNER** **Male / Female**
Name:	**Name:**
Date of birth:	**Date of birth:**
NHS No:	**NHS No:**
Home Address: **Post Code:**	**Home Address:** **Post Code:**

DATE OF SPECIALIST RECOMMENDATION THAT ASSISTED CONCEPTION REQUIRED: (this will be the date that secondary care specialist assessment was completed and the advice was given assisted conception was the appropriate treatment in this case. It should be determined by reference to the date of the clinic letter from specialist to GP relating to this clinic appointment)

SECTION THREE – ELIGIBILITY

Eligibility Criteria	Tick all that apply
Age Female partner intending to become pregnant is aged between 18-40 years OR Female partner intending to become pregnant is aged between 40-42 (Patients are eligible up to the date of their 43rd birthday) AND There is no evidence of low ovarian reserve AND There has been a discussion of the additional implications of IVF and pregnancy at this age (*No new cycle should start after the woman's 43rd birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles*)	☐ ☐ ☐ ☐
Length of relationship Couple have been cohabitating in a stable relationship for a minimum of 2 years	☐
BMI Female partner intending to become pregnant has a BMI between 19 and 30 (*Patients with a higher BMI should be advised about healthy lifestyle interventions including weight management advice. Patients should not be re-referred to tertiary services until their BMI is within the recommended range*)	☐
Smoking Both partners do not smoke (defined as not smoked for at least 4 weeks) *(Patients and their partners who smoke should be offered smoking cessation advice and referral to smoking cessation services)*	☐
Duration of infertility Couple have not conceived after 2 years of regular unprotected intercourse OR For couples where intercourse is not possible, who have not conceived after 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination)	☐ ☐
Previous infertility treatment Female partner intending to become pregnant has never previously undergone any assisted conception treatment, whether NHS- or self-funded	☐
Existing children Neither partner has any living children from this or a previous relationship (this includes adopted children but not fostered)	☐
Welfare of the child The couple have been assessed as meeting the requirement contained within the HFEA Appendix entitled 'Welfare of the child'	☐

Treatment is not funded where patients have undergone sterilisation or unsuccessful reversal of sterilisation

The CCG would expect that where either partner is a smoker, they should be given smoking cessation support in the same manner as the "Stop before your op" scheme for other elective referrals.

SECTION FOUR – STATEMENT CONFIRMING ELIGIBILITY

STATEMENT TO BE SIGNED BY THE REFERRING CLINICIAN

I confirm that the above information is correct and that this couple are eligible for NHS funded IVF treatment. They have been advised that they have a choice of provider for treatment, as listed below.

Referrer's name:

Referrer's signature:

Date of referral:

Agreed Providers (please indicate patient preference)

Leeds RMU ☐

South Tees Hospitals ☐

Other (specify) …………………………………………

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

Please send to:

IVF Funding Request Team
North Yorkshire & Humber CSU Triune Court
Unit 1
Monks Cross
North York
YO32 9GZ

Safe Haven Fax: 01904 694702
Email: nyhcsu.exceptions@nhs.net