Bourn Hall
FERTILITY CLINIC

Referral for Level 2 Fertility Services

This form must be accompanied by a referral letter

Please ensure that best endeavours are used to provide all information requested. Incomplete information may result in Level 2 providers seeking clarity which could lead to a delay, or in cases where important test results are missing, this will result in a return of the referral form to the referrer when those tests are the responsibility of primary care.

1. Referral Criteria

Level 2 services are available to couples fulfilling the following criteria:
(Please **do not** refer patients that do not meet these criteria)

- Compliance with Level 1 requirements of the NICE CG 156, i.e. initial investigations and management by the primary care team. https://www.nice.org.uk/guidance/cg156
- Referral is appropriate for couples who have had regular unprotected sexual intercourse for 12 months and have failed to conceive, unless earlier investigation is indicated.
- Neither partner should have undergone either sterilisation or reversal of sterilisation in the past.
- Treatment may be denied on other medical grounds not explicitly covered in this document.

It should be noted that the following will NOT be eligible for onward referral to Level 3:

- Women aged 41 years 364 days
- Couples with living children from the current or any previous relationships, including adopted children, regardless of whether the child resides with them or not
- Women with BMI under 19 or over 30
- Patients not registered with a GP in Essex/Suffolk for at least 12 months.

Please refer to the Assisted Conception policy for your CCG:

2. GP Details

	Prospective Parent	Partner
Name of registered GP		
Address		
Postcode		
Telephone		
Email		

3. Details of couple referred

If couples are registered with different GP Practices, please ask them to complete the data sharing consent form and follow the process on the consent form. The consent form also gives further information on what the GP should do if consent is not given to share information between GP Practices.

Please note unique identifier here: -

	Prospective Parent	**Partner**
NHS Number		
Name		
Previous name (if applicable)		
Date of Birth		
Address		
Postcode		
Telephone (Home)		
Telephone (Mobile)		
Ethnicity		
Height of Female Partner		
Weight of Female Partner		
Current BMI of Female partner	Date: BMI:	

If the service user requires an interpreter, please specify language

Accessible Information Standards	
Does the service user have additional needs related to:	Please specify below as applicable:
Vision	
Hearing	
Speech	
Other communication difficulties	

4. Pre-Conception Health Screen

We would be grateful if you could provide the following results for both partners.
Please ensure that best endeavours are used to provide all information requested. Incomplete information may result in Level 2 providers seeking clarity which could lead to a delay, or in cases where important test results are missing, this will result in a return of the referral form to the referrer when those tests are the responsibility of primary care.

	Female Partner	**Male Partner**
Rubella status	Record of full immunisation (date)	N/A
	If no record of immunisation, screening results (IU/ml) Result	

Smoker E-cigarette users are classed as e-cigarette users not smokers. See Fertility policy for further information.	☐ Yes / No ☐	☐ Yes / No ☐
Folic Acid supplement being taken https://www.nice.org.uk/guidance/cg156	☐ Yes / No ☐ BMI<30 dose = 400 micrograms	N/A
Cervical smear – date and result of last smear	Date Result	N/A
Semen analysis (should be within the last 12 months) – date and results	N/A	Date Volume Sperm Concentration (million per ml) Total progressive Normal morphology
Serum progesterone at day 21 if regular cycles – date and result	Date Result	N/A
Chlamydia trachomatis test (should be within the last 9 months) – date and result	Date Result	N/A
Other diagnostic tests if available e.g. ultrasound – dates and results		
Please provide reason if early investigation is requested (History of predisposing factors, cancer, woman's age etc.)		
Any other relevant information e.g. allergies, medical history requiring pre-conceptual care, i.e. diabetes, epilepsy, genetic conditions and others. **If yes to the above, please confirm that a referral for pre-conceptual care has occurred.**	☐ Yes / No ☐ ☐ Yes / No ☐	☐ Yes / No ☐ ☐ Yes / No ☐

5. Welfare of the unborn child

Are you aware of anything in the past medical or social history of either partner, which may be of concern with regard to the Welfare of the Unborn Child?

Prospective Parent:	☐ Yes / No ☐
Partner:	☐ Yes / No ☐

In the event of a disclosure A REFERRAL SHOULD NOT BE MADE, instead the GP should contact the CCG Designated Nurse or Doctor and/or local children's services in order to assess the risk.

6. Confirmation from the referring practitioner

The patients understand that acceptance to Level 2 does NOT guarantee acceptance to Level 3 treatment. Where NHS funding for Level 3 treatment is available, patients meeting the criteria will require further referral.

GP Name	Date

(Prospective Parent's GP)

GP Name	Date

(Partner's GP)

The completed form and accompanying letter should be attached to an e-Referral, or sent direct to:

Bourn Hall Clinic
High Street
Bourn
Cambridge
CB23 2TN
bournhall.referral@nhs.net

Office use only	
Date Received	
Date Reviewed	
Accepted	
Comments	
Breach date	
Name & Signature	