NHS
Norfolk and Waveney
Clinical Commissioning Group

Referral for Level 2 Fertility Services

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 prospective parent(s) 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 prospective parent(s) who have had regular unprotected sexual intercourse for 12 months and have failed to conceive unless earlier investigation is indicated.
- Neither prospective parent(s) 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:

- Prospective female parent aged 41 years 364 days
- Prospective parent(s) with living children from the current or any previous relationships, including adopted children, regardless of whether the child resides with them or not
- Prospective female parent with BMI under 19 or over 30
- Prospective parent(s) not registered with a GP in Norfolk and Waveney CCG for at least 12 months

Please refer to the Assisted Conception policy for all access criteria for Norfolk and Waveney CCG:

2. GP Details

	Prospective Parent 1	Prospective Parent 2
Name of registered GP		
Address		
Postcode		
Telephone		
Email		

3. Details of Prospective Parent(s) referred

If prospective parent(s) 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 1	**Prospective Parent 2**
NHS Number		
Name		
Previous name (if applicable)		
Date of Birth		
Address		
Postcode		
Telephone (Home)		
Telephone (Mobile)		
Ethnicity		
Height of Female Prospective Parent		
Weight of Female Prospective Parent		
Current BMI of Female Prospective Parent	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 prospective parent(s)

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	Female Prospective Parent	**Male Prospective Parent**
Rubella status	Record of full immunisation (date) If no record of immunisation, screening results (IU/ml)Result	N/A
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	Please attach full ICE report
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

The welfare of any resulting children is paramount. In order to take into account, the welfare of the child, the clinician should consider factors which are likely to cause serious physical, psychological or medical harm, either to the child to be born or to any existing children of the family.

This is a requirement of the licencing body, Human Fertilisation and Embryology Authority (HFEA).

Is there an explicit and recorded assessment that the social circumstances of the family unit have been considered within the context of the assessment of the welfare of the child
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 of Residential Status

Are prospective parent(s) UK Citizens – **YES** ☐ **NO** ☐
If No – please confirm status:

If indefinite leave to remain or pre-settled status (or other) please provide a copy of relevant documentation i.e. residency visa or 'share code'

Note: Based on the information provided, the Level 2 ACS provider will confirm eligibility of treatment

7.. Confirmation from the referring practitioner

The patients understand that acceptance to level 2 does NOT guarantee acceptance for level 3 treatment.

GP Name	**Date**

(Prospective Parent 1 GP)

GP Name	**Date**

(Prospective Parent 2 GP)

8. Patients Consent

STATEMENT TO BE SIGNED BY THE PROSPECTIVE PARENT(S)

I confirm that I have read and understood the questions above and that the information I/we have given is correct. I understand that if I/we knowingly give false information I/we may be liable to prosecution. I/we give consent for disclosure of information relevant to my/our case from professionals involved.

Prospective Parent 1 Signature: **Date:**

Prospective Parent 2 Signature: **Date**

The completed form should be attached to an e-Referral, or sent direct to one of the following Level 2 providers:

Bourn Hall Clinic
Unit 3, The Apex,
Wymondham
Norfolk NR18 0WP
01953 600150
Email: bournhall.referral@nhs.net

James Paget University Hospitals NHS Foundation Trust
Waveney Suite
Lowestoft Road, Gorleston
Norfolk NR31 6BD
01493 452366

Office use only	
Date Received	
Date Reviewed	
Accepted	☐ Yes / No ☐
Comments	
Breach date	
Name & Signature	