Fertility Clinic Outpatient Referral Process

Burton Fertility
Outwoods House
Belvedere Road
Burton on Trent
Staffs, DE13 0RB

Tel: 01283 593098

Couple present with infertility

Remember

- Female rubella status
- Folic acid
- If female BMI> 30 advise weight loss
- If male BMI> 35 advise weight loss
- Drug history
- Occupational history
- Cervical smear history

History and examination of both partners

- Advise regular intercourse 2 or 3 times a week
- **Do not** use basal body temperature charts or LH detection kits

Advice to both partners on smoking and drinking

FEMALE

Consider early referral if:

- Aged over 35 years
- Amenorrhoea/oligomenorrhoea
- Previous abdo/pelvic surgery
- Previous PID/STD
- Abnormal pelvic exams

- Confirm ovulation with mid-luteal progesterone level: 7 days prior to outset of menstruation if regular cycles (occurring every 24 to 35 days)
- **Do not** measure thyroid function or prolactin if regular cycles

MALE

Consider early referral if:

- Previous genital pathology
- Previous urogenital surgery
- Previous STD
- Varicocele
- Significant systematic illness
- Abnormal genital exam

- Arrange **ONE** semen analysis at BCRM Andrology Laboratory by telephoning the dedicated service line on 01283 593102, leaving patients details. Appointment will sent out directly to patient.

Discuss results with couple and plan future management

Any abnormal test results

- Ask both partners to complete a Welfare of the Child questionnaire
- Ask both partners to complete patient Questionnaires (1 for female & 1 for male)

Can defer referral if history, examination and investigations normal in both partners and duration of infertility <18 months

Referring to Fertility Clinic

- Complete a Fertility Clinic Outpatient Referral form
- Choose slot on Tuesday or Thursday afternoon Fertility Clinic on Choose and Book and Upload Outpatient Referral form.
- Give both partners a Welfare of the Child questionnaire **and ensure they sign sheet 2**
- Give both partners a Patient questionnaire to complete
- Advise patient to return both Welfare of the Child questionnaires and Patient questionnaires directly to the unit/bring with them to their appointment.
- **Advise patients that they may not been seen without their completed forms.**
- Advise patient that their appointment will be confirmed in writing by the hospital
- **Please note that if the Outpatient Referral form is missing, the referral will be rejected**

Form to be uploaded with choose and book appointment

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Fertility Clinic Outpatient Referral

Both partners need to complete a 'Welfare of the Child' and 'Fertility Unit Questionnaire' prior to referral

Female Patient's Name:

Female Patient's NHS No.

Home Telephone Number:

Mobile Number:

Referring GP Name & Address:

Female Patient's Address:

Please confirm advice has been given on the following:

Folic acid ☐ Alcohol ☐

Smoking ☐ Weight loss (if female BMI>30 / Male BMI >35) ☐

Please note this service has set referral guidance and the following tests are required prior to referral. Any referral received without ALL of the test results listed below being included will be returned to the referring GP.

Test results required if the patient has REGULAR cycles	Date	Level	**Test results required if the patient has IRREGULAR cycles**	Date	Level
Day 1-5 FSH & LH			Random FSH & LH		
Mid-luteal progesterone 7 days prior to onset of menses (occurring every 24 to 35 days) (result within last 6 months)			TSH Prolactin		
Rubella status (result within last 5 years)			Rubella status (result within last 5 years)		
Chlamydia status (within last 6 months)			Chlamydia status (within last 6 months)		
Semen analysis (result within last 12 months)			Semen analysis (result within last 12 months)		

Reason for referral (Include symptoms & previous treatments, i.e. x-rays, tests etc)
(consider early referral if female aged over 35 years, amenorrhoea/oligomenorrhoea, previous abdo/pelvic surgery, previous PID/STD, abnormal pelvic exams. Male - previous genital pathology, previous urogenital surgery, previous STD, varicocele, significant systematic illness, abnormal genital exam)

Other relevant past medical history

Relevant medication

Additional clinical details

Communication / Mobility

Form to be given to patient to complete and return direct to unit (address opposite) before/on appointment date

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Female Form

Welfare of the Child: patient history form

About this form

This form should be completed by each patient requesting any fertility treatment regulated by the HFEA, including IUI. In surrogacy arrangements, both the commissioning couple and the surrogate (and her partner, if she has one) should complete this form.

For further information, please refer to guidance note 8 of the HFEA *Code of Practice*.

The information you provide in this form will help determine whether any child you might have is likely to be at risk of serious harm. Decisions are made on a case by case basis. Answering yes to any of the questions does not necessarily mean that treatment will be refused. For further information about the welfare of the child assessment, please refer to www.hfea.gov.uk

1 About you

1.1 First name(s)

1.2 Surname:

1.3 Date of birth (DDMMYY)

1.4 House name or number:

1.5 Street name:

1.6 Town:

1.7 Postcode:

1.8 Country:

1.9 Contact number:

2 Your history

2.1 Do you have any previous convictions related to harming children? Yes ☐ No ☐

If yes, please give details:

2.2 Have any child protection measures been taken regarding your children? Yes ☐ No ☐

If yes, please give details:

Continues on next page

For clinic use only

Place clinic sticker here or fill in by hand

HFEA centre reference ☐☐☐☐

Patient number *Assigned by clinic*

Other relevant forms

2 Your history *continued*

2.3 Is there any serious violence or discord within your family environment? Yes ☐ No ☐

If yes, please give details:

2.4 Do you have any mental or physical conditions? Yes ☐ No ☐

If yes, please give details:

2.5 To your knowledge, is your child at increased risk of any transmissible or inherited disorders? Yes ☐ No ☐

If yes, please give details:

2.6 Do you have any drug or alcohol problems? Yes ☐ No ☐

If yes, please give details:

2.7 Are there any other aspects of your life or medical history which may pose a risk of serious harm to any child you might have or anything which might impair your ability to care for such a child?

Yes ☐ No ☐

If yes, please give details:

Your signature ✗

Date (DDMMYY) D D M M Y Y

Place clinic sticker here or fill in by hand

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HFEA centre reference ☐☐☐☐

Patient number *Assigned by clinic*

Other relevant forms

TO BE COMPLETED BY THE CENTRE

Is there any concern that the prospective parents may not be supportive parents (ie, that they show a lack of commitment to the health, well being and development of the prospective child)? Yes ☐ No ☐

If yes, please specify if and how the wider family and social networks within which the child will be raised have been taken into account.

Further information sought? Yes ☐ No ☐

If yes, specify a) grounds for seeking information, b) type of information sought and c) source of information (GP, social services etc.).

Response from information source:

Further action taken? Yes ☐ No ☐

If yes, please specify what action:

Treatment offered? Yes ☐ No ☐

If no, give grounds for refusal and any steps patient(s) could take to reconsider the decision:

Approver's name

Approver's signature

Position

Date (DDMMYY) D D M M Y Y

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Patient number *Assigned by clinic*

Other relevant forms

Form to be given to patient to complete and return direct to unit (address opposite) before/on appointment date

Male Form

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HFEA centre reference

Patient number *Assigned by clinic*

Other relevant forms

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If yes, please give details:

2.7 Are there any other aspects of your life or medical history which may pose a risk of serious harm to any child you might have or anything which might impair your ability to care for such a child?

Yes ☐ No ☐

If yes, please give details:

Your signature

✗

Date (DDMMYY)

D D M M Y Y

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Female Patient Questionnaire

Title Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Other_____

Present surname _____

Surname at birth _____

First name _____

Date of birth _____ Age _____

Town of birth _____

Country of birth (if not UK) _____

Current address _____

_____ Postcode _____

Occupation _____

Can we send correspondence to your home address as above? Yes ☐ No ☐

Home telephone number _____

Mobile telephone number _____

Can you be contact at work? Yes ☐ No ☐ Work telephone no _____

Your GP's name _____

GP telephone number _____

GP Address _____

Have you attended this hospital before or one in this area? Yes ☐ No ☐

If yes, are you able to give your hospital number? _____

Ethnic origin: White ☐ Indian ☐ Black Caribbean ☐ Pakistani ☐ Black African ☐

Bangladeshi ☐ Chinese ☐ Black Other ☐ Other Asian ☐ Other specify……

Height _____ Weight _____

How long have you been with your current partner? _____

How long have you been trying to become pregnant? _____

Have you ever used contraception? Yes ☐ No ☐

If yes, What type did you use:_____

When did you cease using it: _____

Have you ever had a coil inserted? Yes ☐ No ☐

If yes, For how long did you have the coil? _____

When was it removed? _____

Have you had infertility investigations in the past? Yes ☐ No ☐

If yes, when? _____ Where? _____

What type of investigations/ treatment? _____

Have you ever been treated in a STD or GUM Clinic? Yes ☐ No ☐

If yes, please give details_____

Have you ever had any children/ miscarriage/ termination/ ectopic pregnancies?

Yes ☐ No ☐ If yes, please give details of pregnancies in the box below:

Date	With current partner	Assisted conception e.g. Clomid, IUI, IVF	Details e.g. method of delivery normal/ caesarean/ forceps/ ventouse, number of weeks
1	Yes ☐ No ☐	Yes ☐ No ☐	
2	Yes ☐ No ☐	Yes ☐ No ☐	
3	Yes ☐ No ☐	Yes ☐ No ☐	
4	Yes ☐ No ☐	Yes ☐ No ☐	
5	Yes ☐ No ☐	Yes ☐ No ☐	
6	Yes ☐ No ☐	Yes ☐ No ☐	

Menstrual Cycle

Age at first period _____ How many days between periods (i.e. 1st day of one period to the 1st day of the next period) _____days (Min ____ Max _____) Number of days you bleed? _____

Have you had any pelvic/ vaginal infections/ gynaecology operations? Yes ☐ No ☐

If yes, please give details_____

Have you ever had a smear test? Yes ☐ No ☐

If yes, when was your last smear? _____ Were the results normal? Yes ☐ No ☐

Have you had any treatment to your cervix? Yes ☐ No☐

If yes, please give details _____

General Medical History

Blood group (if known) _____

Do you smoke? Yes ☐ No ☐ If yes, how many per day?_____

How much alcohol do you drink – units per week? _____

(1 unit is a standard glass of wine, half a pint of beer or a single measure of spirits)

Have you had any of the following illnesses?

Diabetes ☐ Chest problems (eg Bronchitis) ☐ Colitis ☐ Hepatitis ☐ HIV+ ☐

Any other illnesses? _____

Have you had any non-gynaecological operations? Yes ☐ No ☐

If yes, please give details_____

Are you allergic to Penicillin? Yes ☐ No ☐ Latex? Yes ☐ No ☐

Any other allergies? _____

Are you currently taking medication, including vitamins or homeopathy?

If yes, please give details _____

Are you currently taking folic acid? Yes ☐ No ☐

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Male Patient Questionnaire

Title Mr ☐ Dr ☐ Prof ☐ Other_____

Present surname _____

Surname at birth _____

First name _____

Date of birth _____ Age _____

Town of birth _____

Country of birth (if not UK) _____

Current address _____

_____ Postcode _____

Occupation _____

Can we send correspondence to your home address as above? Yes ☐ No ☐

Home telephone number _____

Mobile telephone number _____

Can you be contact at work? Yes ☐ No ☐ Work telephone no _____

Your GP's name _____

GP telephone number _____

GP Address _____

Have you attended this hospital before or one in this area? Yes ☐ No ☐

If yes, are you able to give your hospital number? _____

Ethnic origin: White ☐ Indian ☐ Black Caribbean ☐ Pakistani ☐ Black African ☐

Bangladeshi ☐ Chinese ☐ Black Other ☐ Other Asian ☐ Other specify……

Height _____ Weight _____

Have you ever had a pregnancy with your current partner? Yes ☐ No ☐

Or with a previous partner? Yes ☐ No ☐

If yes, please give details _____

Had your testicles descended at birth? Yes ☐ No ☐

If no, please give details _____

Have you ever had torsion (twisting of a testicle)? Yes ☐ No ☐

If yes, please give details _____

Have you had mumps? Yes ☐ No ☐ If yes, how old were you? _____

Have you ever been treated in a STD or GUM Clinic? Yes ☐ No ☐

If yes, please give details _____

Have you had any other genital infections? Yes ☐ No ☐

If yes, please give details_____

Have you had infertility investigations in the past? Yes ☐ No ☐

If yes, when? _____Where? _____

What type of investigations/ treatment? _____

Male's general medical history

Blood group (if known) _____

Do you smoke? Yes ☐ No ☐ If yes, how many per day? _____

How much alcohol do you drink – units per week? _____

(1 unit is a standard glass of wine, half a pint of beer or a single measure of spirits)

Have you had any of the following illnesses?

Diabetes ☐ Chest problems (e.g. Bronchitis) ☐ Colitis ☐ Hepatitis ☐ HIV+ ☐

Any other illnesses? _____

Have you had any operations? Yes ☐ No ☐

If yes, please give details _____

Any allergies? _____

Have you had any illnesses during the last three months? Yes ☐ No ☐

If yes, please give details_____

Are you currently taking medication, vitamins or homeopathy? Yes ☐ No ☐

If yes, please give details _____