

GP REFERRAL FORM

NAME (of patient having treatment)

NHS NUMBER **DATE OF BIRTH**

ADDRESS

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TELEPHONE NO. (daytime) **MOBILE**

Having treatment with a partner **Y / N**

Is patient disabled? **Y / N**

If yes type of disability

Is patient from overseas? **Y / N**

PARTNER NAME

NHS NUMBER **DATE OF BIRTH**

TELEPHONE NO. (daytime)

1. Type of Infertility

	Primary <i>1° = no pregnancy with their gametes</i>	Secondary
Man		
Woman (having treatment)		
Couple		

2. Duration of Infertility (Insert TOTAL duration of infertility to nearest year)

years

3. Previous Pregnancies (Please note that multiple births are classed as a single live birth event)

Total No. of Previous Natural Pregnancies	<input type="text"/>	Total No. of Natural Live Births	<input type="text"/>
Total No. of Previous IVF Pregnancies	<input type="text"/>	Total No. of IVF Live Births	<input type="text"/>
Total No. of Previous Miscarriages	<input type="text"/>	Total No. of Previous Ectopics	<input type="text"/>

4. Cause of Infertility/Reason for Treatment (if known) - (more than 1 may apply)

Female

None	<input type="checkbox"/>	Tubal disorders	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Uterine Problems	<input type="checkbox"/>
Ovulatory Disorders (inc PCO)	<input type="checkbox"/>	Ovarian Failure	<input type="checkbox"/>	Avoidance of Genetic Disorder	<input type="checkbox"/>		<input type="checkbox"/>
None	<input type="checkbox"/>	Male Factor	<input type="checkbox"/>	Unexplained	<input type="checkbox"/>	Other	<input type="checkbox"/>
Immune problems	<input type="checkbox"/>						

Male

None – Female Infertility	<input type="checkbox"/>	Azoospermia (no sperm)	<input type="checkbox"/>
Oligozoospermia (low sperm count)	<input type="checkbox"/>	Other semen problems	<input type="checkbox"/>
Fertility Preservation	<input type="checkbox"/>	Avoidance of Genetic Disorder	<input type="checkbox"/>

5. Other Information/test results

BMI (female)	<input type="text"/>	Day 2 FSH	<input type="text"/>
Rubella immune	<input type="text"/>	Thyroid Function test	<input type="text"/>
Chlamydia status	<input type="text"/>	Prolactin	<input type="text"/>

6. Allergies (inc latex/nuts/eggs/medication)

7. Other Relevant Medical/Surgical Issues

8. GP Details

REFERRING GP NAME GMC No.

SURGERY ADDRESS

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TELEPHONE NO. EMAIL

SIGNATURE DATE