IVF Referral to CARE Fertility (Manchester)

NHS
Trafford

FAO: JULIE MAJEKODUNMI

IVF – REFERRAL FOR TREATMENT

PATIENT DETAILS

Name

Address

Date of Birth

NHS No

Reg. GP

GP Address

Email

ELIGIBILITY DETAILS

The above patient is eligible for **ONE** cycle of IVF treatment and has elected to have this cycle of treatment at CARE Fertility Manchester.

NHS Trafford confirms that it will fund this treatment.

Date NHS Trafford received confirmation of infertility and eligibility from consultant ....

Date of last cycle of treatment (if applicable) ....

Date NHS Trafford letter sent advising patient of Provider choices ....

Date patient accepted treatment offer/referral ....

Date NHS Trafford referred patient for treatment ....

PRIVATE TREATMENT

As far as NHS Trafford is aware the patient has previously had 0 cycles of private IVF treatment.

NHS Trafford will fund patients for the number of cycles stated above, provided this does not exceed three cycles of IVF, as per NICE guidelines.

OTHER ADDITIONAL INFORMATION

NHS Trafford IVF Eligibility Form

Please affix Patient ID Label Here:

FEMALE PATIENT DETAILS	
Surname:	First Name(s):
Address:	
Tel Number:	Date of Birth:
NHS Number:	

Please confirm that the patient/couple meets NHS Trafford's eligibility criteria for assisted conception treatment:

	Yes	No
The couple have failed to conceive after regular unprotected sexual intercourse for 2 years, in the absence of known reproductive pathology.		
Female partner is at least 23 and under 42 years old.		
Female partner's BMI is above 19 and below 30.		
Both partners are non-smokers.		
Both partners have given assurance that their alcohol intake is within Department of Health guidelines.		
Both partners have given assurance that they are not using recreational drugs.		
The couple do not already have a child together.		
Neither partner has been sterilised or has had a reversal of sterilisation.		

If the couple is same sex, please confirm that they have completed 5 cycles of IUI donor insemination. (If Not Applicable, Please Leave Blank)		

If patients are eligible for treatment the GP should now request that they choose a provider and then refer the patient accordingly using the appropriate fax referral form.

If this patient/couple requires further investigations or management prior to a referral for IVF, please do not complete this form. Instead, refer them to an appropriate secondary consultant for fertility investigation.

Referrer Signature:	Date:
Print Name:	NHS Trust:

Please note that any incomplete or inappropriate referrals will be returned to sender

Please attach any relevant medical history