CARE Fertility Bath

01761 434464 email ruh-tr.enquiries-bfc@nhs.net

REFERRAL FOR EGG STORAGE

Screening bloods **must** be taken **prior to referral**. Patients can be referred whilst awaiting results.

The form **must** be signed by a registered medical practitioner. If completed form is to be emailed please also notify CARE Bath by telephone 01761 434464.

Storage **may** be NHS funded for 1-10 years (length of time varies according to CCG and woman's age). Women may have to fund their own storage if they already have children.

<table>
<tr><td rowspan="4">Patient Addressograph
Full name & DOB
Home address
NHS number</td><td>Inpatient / outpatient</td></tr>
<tr><td>Consultant's name</td></tr>
<tr><td>Patient's phone number

Has an appointment already been arranged with CARE Bath? Yes ☐ No ☐</td></tr>
<tr><td>GP</td></tr>
<tr><td>Screening blood tests required
☐ Hepatitis B surface antigen (HBsAg)
☐ Hepatitis B core antibody (anti-HBc)
☐ Hepatitis C
☐ HIV 1 and 2</td><td>Date bloods taken</td></tr>
<tr><td colspan="2">Diagnosis</td></tr>
<tr><td>Planned treatment chemo/radiotherapy</td><td>Proposed starting date</td></tr>
<tr><td colspan="2">Additional information</td></tr>
</table>

Check list for referral criteria – please tick:

- ☐ Proposed cancer treatment has a prospect of cure – i.e. not palliative
- ☐ The fertility of the above named patient is likely to become significantly impaired
- ☐ Must be under 40 years of age
- ☐ Sufficient time exists for cycle of ovarian stimulation without detriment to treatment of malignant condition (absolute minimum time required is 2 weeks)
- ☐ No indication of ovarian failure, or previous treatment which may have caused ovarian failure

Full name of Doctor:_____ Position held:_____

Work address: _____

Signature:_____ Date:_____