GP Referral Form for Fertility Assessment

EFFECTIVE FROM December 2014 – ALL NEW GP REFERRALS

Criteria for Referral for Assessment by Fertility Services:

1. In order to refer a couple for assessment all questions **MUST** be answered.
2. Please refer to your local CCG policy for details of eligibility criteria for assisted conception treatments including Intrauterine Insemination (IUI), Donor Insemination (DI), Oocyte Donation (OD) and in-vitro fertilisation (IVF).
3. If referring for IVF treatment, read eligibility criteria in Fertility policy prior to referral.

Patient Information			
Name:			
Address:		**DoB:**	
		NHS No:	
		Home Tel No:	
		Mobile No:	

To be completed by GP prior to referral to secondary care

Initial Lifestyle advice	Tick
Provide patient information on conception rates and reassurance	
Consider referral to smoking cessation and weight management	
Advise on alcohol intake and recreation drug use	
Recommend folic acid supplementation	
Other lifestyle advice (tight underwear, occupation)	

Failure to conceive after 1 year attempt or 6 cycles of artificial insemination- further investigations and consider referral to secondary care.

Investigations	Date	
Female		
Regular menstrual cycle	☐ YES	☐ NO
Serum FSH Level (Day 1-3)		
Serum LH Level (Day 8)		
Serum Progesterone at mid-luteal:		
Serum Prolactin:		
Serum Testosterone		
Male		
Semen Analysis: (if abnormal repeat in 6 weeks)		
Count		
Motility		
Morphology		

- **Assess and manage ovulation disorders appropriately and consider referral to secondary care at this stage**
- **Refer to secondary care for further investigations for suspected uterine and tubal abnormalities**
- **Refer for unexplained infertility if all hormonal profile and semen analysis normal**

Other investigations (if previous result available):

Investigations	Date	Results
Tubal Surgery		
Laparoscopy & Dye		
Hysteroscopy		
Hysterosalpingogram		
Ultrasound		

Other screening tests:

Screening				
Test	Female		Male	
	Date	Result	Date	Result
Chlamydia Screening				
Rubella				
Cervical Smear				

Referred by:

Signed:	Date:
Print Name:	
Contact Address:	
Email:	Telephone No: