**This form must be fully completed**. If any sections are left blank the referral will be returned.

Completed forms should be submitted electronically via **Fertility RAS Peterborough** (not gynaecology, there is a separate fertility service)

\*Patients must be provided with patient information leaflets prior to referral, available from [www.womenshealthpeterborough.co.uk](http://www.womenshealthpeterborough.co.uk)

Queries: Fertility Nurse Specialists - 01733 673750 or email nwangliaft.fertility@nhs.net.

|  |  |  |
| --- | --- | --- |
|  | **Birth Mother** | **Partner – all information for partner must be included please. Both partners are seen in clinic** |
| Name |  |  |
| NHS Number |  |  |
| Address |  |  |
| Date of Birth |  |  |
| Mobile Phone no. or landline number |  |  |
| Email address |  |  |
| GP Name |  |  |
| GP Surgery |  |  |
| GP Telephone no. (number for secretaries please in case of queries) |  | |
| GP Email |  | |
| Date registered with GP |  |  |
| Language spoken and is Interpreter required? |  |  |
| \*Best practice fertility advice leaflet given |  |  |
| \*Timing intercourse for the fertile time leaflet given |  |  |

\*Welfare of the child (WOC) assessments - Both parents should be questioned directly. Is there any medical or social history that could affect the welfare of any existing or intended child that could result in harm or neglect?

|  |  |
| --- | --- |
| **Birth Mother** | |
| Duration of subfertility |  |
| Any live children from current or previous relationship | Adopted or conceived |
| \*WOC – Any Involvement of family social services |  |
| \*WOC Any criminal convictions |  |
| \*WOC Any drug or alcohol abuse |  |
| \*WOC Any risk of transmissible diseases |  |
| \*Any welfare of the child concerns for existing/future children. |  |
| Height |  |
| Weight |  |
| BMI |  |
| Smoking status |  |
| Menstrual cycles every 25-42 days |  |
| Folic acid. GP to prescribe 5mg if history of diabetes, BMI>30, Crohn’s, gastric surgery, epilepsy | 400mcg standard dose or 5mg |

**Results- birth mother**

|  |  |
| --- | --- |
| Progesterone  (Day 21) | **Report MUST be attached to RAS or be available on ICE** |
| Chlamydia | **Report MUST be attached to RAS or be available on ICE** |
| Rubella | **Report MUST be attached to RAS or be available on ICE** |
| Cervical Smear | **Report MUST be attached to RAS or be available on ICE** |
| TSH | **Report MUST be attached to RAS or be available on ICE** |
| Prolactin | **Report MUST be attached to RAS or be available on ICE** |
| Oestradiol (Day 2-4) | Not essential but please include if available |
| LH (Day 2-4) | Not essential but please include if available |
| Testosterone | Not essential but please include if available |
| FSH (Day 2-4) | Not essential but please include if available |
| High vaginal swab for MC&S | Not essential but please include if available |
| Pelvic ultrasound scan | Not essential but please include if available |
| Laparoscopy/Hysteroscopy | Not essential but please include if available |

|  |  |
| --- | --- |
| **Partner** | |
| Any live children from current or previous relationship | Adopted or conceived |
| \*WOC - Any Involvement of family social services |  |
| \*WOC Any criminal convictions |  |
| \*WOC Any drug or alcohol abuse |  |
| \*WOC Any risk of transmissible diseases |  |
| \*Any welfare of the child concerns for existing children or future children. |  |
| Height |  |
| Weight |  |
| BMI |  |
| Smoking status |  |

|  |
| --- |
| **Semen analysis result(s)**  **All semen analysis reports must be sent with referral please. Failure to attach at least one semen analysis result will result in the referral being rejected. If the patient is at another surgery it is your responsibility to obtain the report and send it with the referral. Many thanks** |

|  |  |  |
| --- | --- | --- |
|  | Birth Mother | Partner |
| Relevant medical history |  |  |
| Relevant surgical history |  |  |
| Current medications |  |  |

Please include any relevant specialist letters with the referral.

**Referring GP:**

|  |  |
| --- | --- |
| Date | Signed |
| Print Name | |
| Contact email in case of query with referral: | |