**FERTILITY ASSESSMENT AND TREATMENT**

**Prior Approval Treatment: Application Form**

Please refer to the Generic EBI application form for applications that DO NOT MEET Prior Approval criteria

**Please complete electronically – Handwritten applications can no longer be processed**

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| **Date of Application**  |  |
| **PATIENT INFORMATION** | **PRIVATE & CONFIDENTIAL** | **SM** |  |  |  |  |  |
| **Does this case need to be reviewed urgently due to clinical need?** *If yes, please explain.* | [ ]  **YES** [ ]  **NO** | If yes, please state any clinical reasons that may make this application clinically urgent:      |
| **Name of Prospective birth parent** |  | **NHS Number** |  | **DOB** |  |
| **Name of Partner** |  | **NHS Number** |  | **DOB** |  |
| **Address** |  | **Post Code**  |  |
| **I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or their legitimate representative) prior to disclosure of their personal details** for the purpose of a Panel/EBI team to decide whether this application will be accepted, and treatment funded. *[The information shall be legitimately shared under Article 6(1) (e) Public Task and Article 9(2) (h) Provision of Health Treatment of the GDPR].* **By submitting this application form I, the referring clinician, confirm the patient or patient representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given.** |
| **Applications received without a Clinician / GP name CANNOT BE PROCESSED** |
| **Details of the GP OR Clinician completing the application form** |
| **Name of GP / Clinician**  |  |
| **Role / Job Title** |  |
| **GP Practice or Hospital Address** |  | **Post Code**  |  |
| **Telephone** |  | **Email** |  |
| ***Please note.* If a consultant is completing the application form on behalf of the patient, GP details are also required. Please state GP details below and include full Medical Practice address** |
| **GP Name** |  | **GP Practice** |  |

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| **CLINICAL EVIDENCE STATEMENT**This application CANNOT BE PROCESSED unless clear clinical evidence to demonstrate policy criteria is being met, is provided with the application form. The clinical evidence obtained by a clinician will usually be recorded in notes or letters and copies of all relevant evidence should be supplied.​**Clinical evidence required to demonstrate criteria have been met:*** **Clear and full relevant history** e.g. Symptoms, duration and time course, fluctuations, nature, and severity, exacerbating and relieving factors, and clinical impact upon activities of essential daily living
* **Copies of all relevant Clinical Notes**
* **GP summary and/ or patient management plan**

**Patient letter to support clinical evidence:**A letter from the patient, written to support clinical evidence provided, may be considered with an application e.g., clinical impact upon activities of essential daily living. ***Please Note.*** According to NHSE guidance, Social, Emotional and Environmental factors *i.e., income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application.**Do you comply with this statement? *Please* *mark* *the box with an* X** **[ ]**  |

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| **CRITERIA** |
| 1. Referral is supported by the referring General Practitioner and Gynaecologist
 | **YES** **[ ]**  |
| 1. BMI of prospective birth parent is > 19 & < 30

**Within the last 2 months and recorded by a Clinician** | **BMI** | **Date Recorded** |
|  |  |
| 1. Age of prospective birth parent is between 23 & 39 years of ageinclusive
 | **Age In Years:** |  |
| 1. Age of male, where applicable is <54 years of age
 | **Age In Years:** |  |
| 1. There are no children from previous relationships **AND** there are no living children from this relationship (Including adopted children but excluding fostered children)
 | **YES [ ]**  |
| 1. The couple have been
2. in a stable relationship for at least 2 years
3. trying to conceive for a minimum of 2 years (where applicable to the couple)
 | **YES [ ]  NO [ ]** **YES [ ]  NO [ ]**  |
| 1. There is clinical evidence provided with this application (where applicable to the couple) to support:

Unexplained Infertility or Subfertility **[ ]**  **OR**A diagnosed cause of absolute infertility which **[ ]**  precludes any possibility of natural conception  (0% of pregnancy) |
| **GP (Primary Care) visit date/s with reference to fertility:** | **Consultants (Secondary Care) visit date/s with reference to fertility:** |
| 1. Both patients do not smoke
 | **YES [ ]  NO [ ]**  |
| If either partner smokes **do not apply** for NHS funded fertility treatment until smoking has ceased for a period of 3 months and you are able to provide the evidence of a CO reading or provide assurance your patients are non-smokers |
| **OR** |
| 1. Where either partner has ceased smoking for a period of at least 3 months or more and have accessed the NHS Somerset Smokefree services where a CO reading can be obtained, *please include a copy of the CO reading to support the following information*
 |
| Patient Name:       | Date stopped:      | Date & level of CO reading:      |
| Patient Name:      | Date Stopped:      | Date & level of CO reading:      |
| 1. Where there is no CO reading available the EBI Service can take a clinician’s assurance that their patients are non-smokers
 |
| I as the patient(s) clinician confirm both my patients have been non-smokers for 3 months  | **YES [ ]**  |
| Patient Name:       | Date stopped:      |
| Patient Name:       | Date stopped:      |
| 1. Both patients have not undergone a sterilisation procedure
 | **YES** **[ ]**  |
| 1. Both patients (as a couple) have not received previous NHS funded fertility treatment
 | **YES** **[ ]**  |
| **Additional supporting Information can be typed here or attached:**      |

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| **Evidence provided to support the above criteria have been met:****Is a Patient Management Plan included with this application?*****Are copies of relevant clinical notes included with this application?*****Is a Referral Letter included with this application?*****Are all relevant Clinician(s) Letters included with this application?*** **Is a Patient Letter to support clinical evidence, included with this application?****By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete.** *Please mark the boxes below.*Have you referred to the relevant NHS Somerset ICB EBI policy prior to completing this PA application form? Have you had a conversation with the patient about the most significant benefits and risks of the intervention? Have you attached all the clinical correspondence to evidence that criteria have been met?Have you discussed with the patient whether any additional communication requirements are needed? e.g., different language, format. | **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **[ ]** **[ ]** **[ ]** **[ ]**  |

**Email the completed Prior Approval form & clear clinical evidence to support the application to:** **ebisomerset@nhs.net**

***Please note.* Printed / scanned application forms sent by email cannot be processed**