**SECONDARY CARE REFERRAL Form**

**FERTILITY PRESERVATION - Prior to oncology and other medical treatments**

**Please refer to the Fertility Assessment & Treatment Policy section F2**

1. The treating NHS provider is to forward the completed form to an appropriate NHS service
2. A copy of this completed form needs to be forwarded to [ebisomerset@nhs.net](mailto:ebisomerset@nhs.net)
3. Screening for hepatitis B (HBsAg and anti-HBc), hepatitis C and HIV must be arranged prior to a referral for fertility preservation. Patients can be referred whilst awaiting results

**Please complete electronically – Hand written applications can no longer be processed**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | |  | | | | **Gender** | |  | | | | |
| **Address** | |  | | | | | | | | | | |
| **Date of Birth** | |  | | **NHS Number** | |  | | | | | | |
| **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.** | | | | | | | | | | | | |
| **Patient’s BMI** | | |  | | --- | |  | | **Date Recorded by Clinician** | | | |  | | --- | |  | | | | | | | |
| **Patient’s Smoking Status** | |  | | | | | | | | | | |
| **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** | |  | | | | | | | | | | |
| **Telephone** | |  | **Email** | |  | | | | | | | |
| ***Please note.* If the clinician is completing the application form on behalf of the patient, GP details are also required. Please state GP details below.** | | | | | | | | | | | | |
| **GP Name** |  | | **GP Practice and Address** | |  | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PLEASE REFER TO THE FERTILTIY ASSESSMENT & TREATMENT POLICY SECTION F2**  **PRIOR TO COMPLETING THIS REFERRAL FORM** | | | | |
| The clinical evidence supports that the fertility of the above named patient is or is likely to become significantly impaired by the clinical treatment proposed | | |  | |
| The patient’s ICB will be notified with a copy of this form | | |  | |
| The patient has no living offspring from their current relationship or previous relationships, including adopted children but excluding fostered children | | |  | |
| Female patient is not older than 40 years of age; age in years |  | Male patients is not older than 54 years of age; age in years |  | |
| Diagnosis |  | | | |
| Planned Treatment for patient  (chemo/radiotherapy) |  | | | |
| Proposed Starting Date of Treatment |  | | | |
| Date Bloods sent for hepatitis B (HBsAg and anti-HBc), hepatitisC, HIV and syphilis screening | Please input dates: | | | |
| This referral complies with the algorithm in the “Referring oncology patients to BFC” protocol | | | |  |
| **Additional information can be typed here or attached:** | | | | |
| Funding for NHS Somerset ICB patients who fulfil the criteria detailed within the NHS Somerset ICB Fertility Assessment and Treatment Policy will be:   * Up to 5 years or up to 25 years of age, if age is less than 20 years at the time of preservation * Funding for storage will cease 6 months following the death of the patient or if the patient or their partner reaches the upper age limit * If continued funding is required a funding application should be made to the ICB’s Evidence Based Interventions Panel with evidence of clinical exceptionality   **Once the period of NHS funding ceases**, patients or their family can elect to self-fund for a further period, not to exceed appropriate HFEA regulations on length of storage | | | | |

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