**SECONDARY CARE REFERRAL FORM**

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

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

**Please complete electronically – Handwritten applications CANNOT 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** | |  | | | | **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** | | | | | | | | | | | | |
| **The Clinician** completing the application form please put your details below | | | | | | | | | | | | |
| **Name of GP / Clinician** | |  | | | | | | | | | | |
| **Role / Job Title** | |  | | | | | | | | | | |
| **GP Practice or Hospital Address** | |  | | | | | | | | | | |
| **Telephone** | |  | **Email** | |  | | | | | | | |
| **Ple*ase note.* If the clinician completing this application form is not the patients GP please input the patients GP details below** | | | | | | | | | | | | |
| **GP Name** |  | | **GP Practice and Address** | |  | | | | | | | |

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| **PRIOR TO COMPLETING THIS REFERRAL FORM**  **PLEASE REFER TO THE FERTILITY ASSESSMENT & TREATMENT POLICY SECTION F2** | | | | |
| 1. 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 | | |  | |
| 1. A copy of this completed form will be email to [somicb.ebisomerset@nhs.net](mailto:somicb.ebisomerset@nhs.net) | | |  | |
| 1. The treating NHS provider will forward this completed form to an NHS fertility service | | |  | |
| 1. 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 | | |  | |
| 1. The patient has no living offspring from their current relationship or previous relationships, including adopted children but excluding fostered children | | |  | |
| 1. Female patient is not older than 40 years of age; age in years |  | 1. Male patient is not older than 54 years of age |  | |
| 1. Diagnosis |  | | | |
| 1. Planned Treatment for patient (chemo/radiotherapy) |  | | | |
| 1. Proposed Starting Date of Treatment |  | | | |
| 1. Date Bloods sent for hepatitis B (HBsAg and anti-HBc), hepatitisC, HIV and syphilis screening | Please input dates: | | | |
| 1. This referral complies with the algorithm in the “Referring oncology patients to BFC” protocol | | | |  |
| **Please Note**  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, where the patients age is less than 20 years at the time of preservation * Funding for storage will stop after 6 months following   + the death of a 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 | | | | |
| **Additional information can be typed here or attached:** | | | | |