**FERTILITY ASSESSMENT AND TREATMENT**

**Prior Approval Treatment - Application Form**

**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 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*****Please note.*** This application CANNOT BE PROCESSED without relevant clinical evidence to demonstrate that the Policy Criteria for the requested treatment has been met by the patient.  Copies of relevant clinical evidence should be provided with the application as follows:* **Relevant clinical history relating to the intervention requested** e.g. symptoms, duration and time course, fluctuations, nature and severity, exacerbating and relieving factors, and clinical impact upon activities of essential daily living. This may include all relevant consultation notes /letters.
* **Relevant summary of medical history**
* **All relevant Diagnostic Reports and Investigation Results**
* **All relevant Secondary Care Reports and correspondence relating to the intervention requested**
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| **CRITERIA** |
| 1. **For individuals on a visa in the UK,** Department of Health (DoH) regulations – August 2017 state that NHS-funded fertility treatment, including IVF, is NOT available to prospective parents, even if they have paid the Immigration Health Surcharge (IHS).  For more information, please see NHS Somerset Fertility policy at [Evidence Based Interventions - NHS Somerset ICB](https://nhssomerset.nhs.uk/evidence-based-interventions/) and the Department of Health (DoH) guidance for charging overseas visitors in England at: [Charging overseas visitors in England: guidance for providers of NHS services - GOV.UK](https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors/charging-overseas-visitors-in-england-guidance-for-providers-of-nhs-services#the-immigration-health-surcharge-ihs)
 |
| 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*
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| 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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| **Clinical Evidence provided to support the application.** *Please, indicate the documents included**in this application:***Relevant clinical history relating to the requested intervention****is included with this application****A Referral Letter is included with this application****Relevant diagnostic reports and/or investigation results are included with this application****Clinician Letter/s are included with this application****A Patient Letter to support relevant clinical evidence is included with this application****By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete.**  | **YES** **[ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]** **YES [ ]  NO [ ]**  |

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