**PRIOR APPROVAL REQUEST  
Gamete Storage**Hertfordshire and west Essex Evidence Based Intervention policies can be viewed at  
<https://www.hweclinicalguidance.nhs.uk/clinical-policies>

**Please complete and return this form along with clinic letter/supporting evidence to:** [priorapproval.hweicb@nhs.net](mailto:priorapproval.hweicb@nhs.net) Tel: 01707 685354

|  |  |  |
| --- | --- | --- |
| **Patient consent** | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB. | Please tick |

|  |  |
| --- | --- |
| **Date form completed** |  |
| **Urgency** | Routine (5 working day turnaround time)  Urgent (2 working day turnaround time)  **Note: An urgent request is one in which a delay may put the patient’s life at risk.**  **Turnaround times commence the working day after receipt of the funding application** |
| **Patient details**  **Please complete all or attach patient sticker** | Name: Date of birth: - - / - - / - - - -  Address:  Telephone number:  NHS No:  Hospital No:  GP Name: Practice: |
| **Applying Clinician’s details** | Consultant Name: Hospital/Organisation:  Contact details:  (Including email) |
| **Declaration** | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. |

**Conditions considered appropriate for gamete cryopreservation are:**

|  |  |
| --- | --- |
|  | Medical conditions requiring treatment with cytotoxic drugs (including malignancies)  **OR** |
| Conditions requiring total body irradiation or radiotherapy that may affect an individual’s reproductive organs.  **OR** |
| Conditions requiring male urological or female gynaecological surgery, which are likely to lead to permanent infertility (including gender reassignment surgery). When requested under gender reassignment surgery, the patient should be undergoing treatment at a nationally accredited clinic.  **OR** |
| Hormone therapy causing permanent infertility secondary to the inability to produce gametes. |

**PLEASE PROVIDE EVIDENCE**

**The following conditions must also be met:**

|  |  |
| --- | --- |
| **2.** | After thorough counselling and a discussion regarding risks and implications of the procedure the patient would like to have gamete storage (shared decision making)  **AND** |
| The patient is aware that funding for gamete retrieval and cryopreservation of material does not guarantee future funding of assisted conception or fertility treatment.  **AND** |
| The patient has not undergone previous sterilisation, even if the procedure has been reversed.  **AND** |
| Registered with a GP |
| Female patients must be of reproductive age up to 43 years old. |

|  |
| --- |
| **For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request form can be submitted to the IFR team.** |

|  |  |
| --- | --- |
| **Shared decision making** | Patients should be supported with their decisions. Resources that can support implementation of shared decision making can be found on the NHS England website:  <https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/> |