 **Request for Funding**

**Assisted Conception – Specialist Fertility Treatment**

All referrals from secondary care or community gynaecology services must have funding prior approved before the referral is made to one of the locally commissioned specialist fertility services.

Please securely email the completed pages 1 – 5 of this form to priorapproval.hweicb@nhs.net and attach copies of any relevant correspondence or clinical letters/reports.

Once funding is approved, refer the patient to their chosen provider and include ALL pages of this form.

If you have any questions, contact the EBI & IFR team on 01707 685354.

Couples who do not meet the policy eligibility criteria and who are considered to have exceptional clinical circumstances can have an Individual Funding Request submitted by a clinician.

The IFR policy and form can be found at <https://www.hweclinicalguidance.nhs.uk/clinical-policies>

|  |  |  |
| --- | --- | --- |
| **Patient consent to share data** *Mark as appropriate* | **Yes** | **No** |
| The couple are aware of this funding request and referral, and they consent to the content of this form being shared with the ICB Clinical Funding Team and specialist fertility provider?  |  |  |
| **Patient Information** |
| **Name:** |  |
| **Address:** |  | **DOB:** |  |
| **NHS No:** |  |
| **Tel No:** |  |
| **GP Surgery** |  | **GP Tel no. and email address** |  |
| **Length of time registered at this surgery** |  |
| **Partner Information** |
| **Name:** |  |
| **Address:** |  | **DOB:** |  |
| **NHS No:** |  |
| **Tel No:** |  |
| **GP surgery** |  | **GP Tel no. and email address** |  |
| **Length of time registered at this surgery** |  |
| **Consultant Information** |
| **Sign and print name**  |  | **Telephone No:** |  |
| **Hospital or** **community service**  |  |
| **Date form completed:** |  |

|  |  |
| --- | --- |
| **Eligibility Criteria** | **Response** |
| **The couple have unexplained infertility for at least three years of ovulatory cycles, despite regular unprotected vaginal sexual intercourse (please provide clinic letter / GP referral to secondary care form). Please state date couple started to try for a pregnancy.** | Yes / NoDate: |
| **Or** **The couple have unexplained infertility after 12 rounds of IUI** | Yes / No |
| **Date first presented to GP – please provide referral if available** | Date: |
| **Date referred for subfertility investigations.** | Date: |
| **Or****State the diagnosed cause of absolute infertility which precludes any possibility of natural conception.**  |  |
| **In the case of male factor infertility please state the severity****Mild** - The effect on the chance of pregnancy occurring through vaginal intercourse would be similar to people with unexplained infertility / subfertility.**Severe** - Precludes any possibility of natural conception i.e., absolute infertility. | Mild / Severe |
| **In the case of male factor infertility****Where preliminary semen analysis is abnormal, have appropriate investigations and management (including genetics) been carried out ie: onward referral not indicated?** | Yes / No |
| **Have either of the couple had any previous IUI or IVF cycles?** **(NHS or self-funded; within or outside the UK)** | Yes / No |
| **Has the male partner ever received NHS funded IVF treatment for his infertility either in this current relationship or in a previous relationship?** | Yes / No  |
| **Age of female at date of referral to IVF provider service**NB: for women over the age of 42 funding will be valid until their 43rd birthday. | Years:  |
| **BMI of female patient (receiving treatment)**(Must be between 19-30 kg/m2 and measured within past 3 months) | BMI:Date measured: |
| **BMI of male partner** (Must be less than 30 kg/m2 and measured within past 3 months) | BMI:Date measured: |
| **AMH level of more than 5.4pmol/l measured within the last 6 months.** Please provide report.Or, If AMH cannot be requested, an FSH lower than 8.9 IU/l measured on day 1-3 of any menstrual cycle measured within the last 6 months. Please provide report.**Only tests arranged through NHS primary, community, or secondary care services will be accepted for the funding application – please confirm.** | Result: Date taken:Yes |
| **Both parties MUST be registered with a GP within HWE ICB. How long have the couple been registered?**If less than 12 months of GP registration, they must demonstrate residency in the ICB area for at least 12 months prior to referral. This evidence must be attached.  | Patient since:Partner since: |
| **Patient and partner are both non-smokers or have quit or switched to e-cigarettes for at least 8 weeks?** | Patient: Yes / NoPartner: Yes / No  |
| **Are there any living children (including adopted) from either the patient or their partner’s current or previous relationships, regardless of whether the child resides with them?** | Yes / No |
| **Have either the patient or their partner ever been sterilised or had sterilisation reversed?** | Yes / No |
| **Is the female patient rubella immune? Evidence must be attached** | Yes / No |
| **HIV1, HIV2, Hepatitis B & Hepatitis C results for both partners are all dated within the last 2 months from the date the sample was obtained.** This is to facilitate the implementation of the HFEA guidelines of a 3-month duration between blood test date and when the patient first provides their gametes for use in fertility treatment.**The results of these tests are not required for the funding application and as such, should remain confidential for the patient.** | Patient Yes / NoDate of test:Partner Yes / No Date of test:  |
| **Chlamydia screening** | Patient Yes / NoDate of test:Partner Yes / No Date of test:  |
| **Cervical smear** | Yes / NoDate of test: |
| **Has the female partner receiving treatment had a pregnancy in the last 3 years (Includes any miscarriages or ectopic pregnancies)?**If yes, please provide dates of pregnancy and details of outcome.  | Yes / No Date:Outcome: |
| **Does either partner have any medical conditions which may impact on the IVF treatment or their safety?**If yes, please provide full details in a supporting clinic letter. | Yes / No  |
| **Welfare of the Unborn Child** Is there any reason, due to past medical or social history of either partner, why there may be a concern for the welfare of the child which may be born? (*Includes history of social care or crime against a child and* takes into account the importance of a stable and supportive environment for children) *If the answer is ‘Yes’, but you still wish to refer the couple, please provide full details in a supporting clinic letter* | Yes / No |
| **NHS funded IUI. Have the couple had 6 cycles of self-funded unstimulated IUI?****If yes, please provide supporting evidence.** | Yes / No  |

|  |  |  |
| --- | --- | --- |
| **Investigations for female partner receiving treatment** | **Date:** | **Result:** |
| **Ultrasound or pelvic/uterine assessment (specify procedure):** |  |  |
| **LH (day 2-4):** |  |  |
| **Estradiol (day 2-4):** |  |  |
| **Tubal Patency** |  |  |

|  |
| --- |
| **Male investigations** |
| **Semen analysis** | Date: | Volume:  |
| Sperm Count:  | Progressively motiles=: | Normal forms: |
| **Repeat semen analysis**  | Date: | Volume: |
| Sperm Count: | Progressively motiles=: | Normal forms: |

|  |
| --- |
| **Sperm storage (if required)**  |
| Nature of diagnosis requiring this procedure: | Date of diagnosis: |
| Planned treatment/surgery: | Treatment start date: |

|  |  |
| --- | --- |
| **Procedure requested** |  *Tick* |
| **IVF with or without ICSI** (Standard package will include):* Initial consultation, follow up consultation, and counselling sessions.
* All ultrasound scans and hormone assessments during the treatment cycle
* Oocyte stimulation
* Oocyte recovery - by vaginal ultrasound guided aspiration under sedation or local anaesthesia; laparoscopy as appropriate under general anaesthesia
* IVF or ICSI to produce embryos and blastocyst culture as appropriate.
* Embryo or blastocyst transfer into uterine cavity.
* Pregnancy test and a maximum of two scans to establish pregnancy viability.
* Drug costs and sperm preparation
 |  |
| **Embryo/blastocyst freezing and storage.**Commissioned as part of the service requirement and will be funded for up to 12 months following completion of NHS Treatment. |  |
| **Specialised surgical sperm recovery** (TESA/PESA)This is the specialist commissioning responsibility of NHS England. Sperm storage will be funded by the ICB at one of our commissioned fertility providers only and for up to 12 months following completion of the NHS England specialist surgical sperm retrieval.  |  |
| **IUI- unstimulated**  |  |
| **Donor oocyte cycle** For individual with embryo/blastocyst stored(Must be self-sourced and self-funded by the couple) |  |
| **Donor Sperm insemination** (Donor sperm must be self-sourced and self-funded by the couple) |  |
| **\*Chronic Viral Infections** Patients with chronic viral infections who are eligible for IVF treatment should be referred to one of the commissioned providers below who have the appropriate processing facilities to accommodate these patients. These are marked with a \* |  |

|  |
| --- |
| **Provider Choice** *(tick as appropriate)* *\*Has appropriate processing facilities to accommodate patients with chronic viral infections* |
| **Bourn Hall Clinic** **Bourn, Cambridge**High StreetBournCambridge CB23 2TN**Tel**: 01954 717210 **Email:**bournhall.referral@nhs.net**Bourn Hall Clinic** **Colchester, Essex**Charter CourtNewcomen WayColchesterEssex CO4 9YA**Tel:** 01954 717210**Email:**bournhall.referral@nhs.net**Bourn Hall Clinic** **Norwich**Unit 3 The ApexGateway 11, Farrier CloseWymondhamNorfolk NR18 0WF**Tel:** 01954 717210**Email:**bournhall.referral@nhs.net**Bourn Hall Clinic** **Wickford, Essex**25 London RoadWickfordEssex SS12 0AW**Tel:** 01954 717210**Email:**bournhall.referral@nhs.net [www.bournhall.co.uk](http://www.bournhall.co.uk) **General enquiries:** info@bourn-hall.com | **CREATE Fertility Hertfordshire**Colney Medical Centre, 45-47 Kings Road, St Albans, AL2 1ES**Tel:** 0333 240 7300**Email:** Create.fertility@nhs.net **\*CREATE Fertility St Paul’s**150 Cheapside,City of LondonLondon EC2V 6ET**Tel:** 0333 240 7300**Email:** Create.fertility@nhs.net **CREATE Fertility Wimbledon**St Georges House 3-5 Pepys RoadWest Wimbledon SW20 8NJ**Tel:** 0333 240 7300**Email:** **create.fertility@nhs.net** | **\*IVF Hammersmith****Boston Place Fertility**20 Boston Place London NW1 6ER**Tel:** 0207 993 0870**Email:** oxford.fertilityclinic@nhs.net [www.bostonplace.co.uk](http://www.thefertilitypartnership.com)**\*IVF Hammersmith****Oxford Fertility**Institute of Reproductive Sciences, Oxford Business Park North, Alec Issigonis Way, Oxford OX4 2HW**Tel:** 01865 782 800**Email:** oxford.fertilityclinic@nhs.net [www.oxfordfertility.co.uk](http://www.oxfordfertility.co.uk)**\*IVF Hammersmith** **Simply Fertility**Essex Healthcare Park, West Hanningfield Road, Great Baddow, Chelmsford, CM2 8FR**Tel:** 01245 201 544**Email:** oxford.fertilityclinic@nhs.net [www.simply-fertility.com](http://www.simply-fertility.com) |
|  |  **Cambridge IVF**Kefford HouseMaris LaneCambridgeCB2 9LG**Tel:** 01223 349010**Email:** add-tr.CambridgeIVF@nhs.net  | **\*Care Fertility London**Park Lorne, 111 Park Rd, Marylebone, London, NW8 7LJ**Tel:** 020 7616 6767**Email**: carefertility.london@nhs.net **\*Care Fertility Northampton** 67 Cliftonville, The Avenue, Northampton, NN1 5BT**Tel:** 01604 601606**Email**: care.northampton@nhs.net[www.carefertility.com](https://www.carefertility.com/) |

**REFERRAL INFORMATION ONLY**

**NOT REQUIRED FOR THE APPLICATION FOR FUNDING**

|  |
| --- |
| **Clinical Information** |
| **Number of TOPs:** |  |
| **Number of miscarriages/ectopic:** |  |

|  |
| --- |
| **Screening** **HIV & Hep B and C Must be dated within the last 2 months to facilitate implementation of HFEA guidelines on 3-month duration between the date of the test and start of treatment** |
| **Test** | **Female** | **Male** |
| **Date of test** | **Results** | **Date of test** | **Results** |
| **HIV Screening** |  |  |  |  |
| **Hep B Surface Antigen**  |  |  |  |  |
| **Hep B Core Antibody** |  |  |  |  |
| **Chlamydia Screening** |  |  |  |  |
| **Hep C** |  |  |  |  |
| **Haemoglobinopathy Electrophoresis (if indicated** |  |  |  |  |
| **Rubella** |  |  |  |  |
| **Cervical Smear** |  |  |  |  |
|  **If any investigations are out of date at the point of referral (after funding has been approved)** **it is the responsibility of the secondary care provider to repeat these tests** |

|  |  |
| --- | --- |
| **Any other relevant information, e.g., allergies or medical history requiring pre-conceptual care i.e., diabetes, epilepsy, genetic conditions, and others.****If yes to the above, please confirm that a referral for pre-conceptual care has occurred.**  | **Patient**: Yes / No**Partner**:Yes / No |
| **Details** |

I, the referring clinician confirm that the couple meet the ICB IVF policy eligibility criteria and funding has been prior approved.

Signature: Date:

Name and Position:

Prior Approval reference number **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **This must be stated on all invoices to enable payment of treatment provided.**