Patient Name:	<Patient Name>
Address:	<Patient Address>
Date of Birth:	<Date of birth>
NHS Number:	<NHS number>
Consultant/Service to whom referral will be made:	
Institution:	

NHS
West Suffolk
Clinical Commissioning Group

Please send this form with the referral letter or to the consultant who you sent the referral to

Lifestyle Information		
Latest BMI: <Latest BMI>	Latest BP: <Latest BP>	Smoking Status:
Has the patient been referred for:	☐ Weight Management	☐ Smoking Cessation

T40 Cyropreservation of sperm, Oocytes and Embryos in Patients Whose treatment Poses a Risk to their Fertility

Information Governance Statement

All Prior Approval Requests must be reviewed by the clinical commissioning group (CCG) as the statutory body responsible for funding decisions. This application form and other supporting information supplied may be shared with the CCG. If so, personal information will be retained only for the purposes of this Prior Approval Request and, in some cases, may be used for invoicing and payment reconciliation. The patient's medical records may be used for the purpose of clinical audit which will be completed by a clinician. Anonymised information may also be shared as part of the CCG reporting process.

Does the patient consent to the sharing of their personal information? Y ☐ / N ☐

Refusal of consent will not preclude application of this referral. However, the referring body must ensure that all personal identifiable data is redacted from this application.

Instructions for use:

To Consultants: Please refer to the T40 policy and complete the boxes below and ensure there is evidence available to support that the criteria are met

This policy states eligibility for fertility cryopreservation for patients receiving NHS-funded cytotoxic treatments that can cause permanent infertility, provided they meet the access criteria set out in the policy. Cancer patients undergoing chemotherapy and/or radiotherapy are recognised as the main candidates in this context but this policy applies to all patients receiving such cytotoxic treatments, regardless of the underlying condition (malignant or non-malignant).

Ineligible patients include:
In ordinary circumstances*, referral/treatment should not be considered if:

The patient has undergone a previous sterilisation (even if reversed)	Y ☐ / N ☐
The patient is infertile due to an existing congenital disorder	Y ☐ / N ☐
The patient wishes to have gametes frozen for non-medical or non-surgical reasons, such as for social reasons.	Y ☐ / N ☐

Version No	Updated by	Date updated
2.1	V Stearn	Feb 2017

WSCCG will **only** fund Cryopreservation when the following criteria have been met:

Oocyte or embryo cryopreservation should offered to women only if: They are well enough to undergo ovarian stimulation and collection AND	Y ☐ / N ☐
This will not worsen their condition AND	Y ☐ / N ☐
Enough time is available before the start of their cancer treatment AND	Y ☐ / N ☐
The womans age is less than 42 In line with NICE CG 156 and the existing fertility policy (T39)	Y ☐ / N ☐ Age:
There is no lower age limit for gamete or embryo cryopreservation as long as it is clinically appropriate For men cryopreservation of sperm is available to those less than 55 years of age In line with NICE CG 156 and the existing fertility policy (T39)	Y ☐ / N ☐ Age:
For cancer patients: The patient must be registered with a GP practice that is part of WSCCG at the point at which referral for access to cryopreservation storage is made For patients with non-malignant conditions: The patient must be registered with a GP practice that is part of WSCCG at the time of diagnosis of the condition	Y ☐ / N ☐ Y ☐ / N ☐
The patient has provided written consent to treatment and gamete storage	Y ☐ / N ☐
The patient should be informed that the above criteria relate to cryopreservation only. CCG eligibility criteria used in conventional infertility treatment will apply when it comes to funding and using stored material for assisted conception in line with the CCG fertility policy at the time of use	Y ☐ / N ☐

[1]f the clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG's Individual funding request policy for further information.

Consultant use only

Please complete the following and file for future compliance audit.

Referral criteria is met and Clinical details documented in patient notes: yes / no

Signature…….

Date …….

Consultant name: …….
Please print

Provider: ……

GP use only

Practice stamp/address
<GP Details>

Usual GP
<GP Name>

Referring clinician: ……..

Date: ……..

Commissioner's use only

Criteria met as per policy: yes / no

Compliance with notes: yes / no

Audit date:
……

Audited by:
……..
Please print

(GP/Cons)

Version No	Updated by	Date updated
2.1	V Stearn	Feb 2017