Patient Name:	${Title_and_surname} ${Forename}
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 referal to

Lifestyle Information		
Latest BMI: ${Latest_BMI}	Latest BP: ${Latest_BP}	Smoking Status:
Has the patient been referred for:	☐ Weight Management	☐ Smoking Cessation

T34 Policy: Referral for Secondary Care Level 2 Subfertility Treatment

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 Referring Clinicians (e.g. GP's): Please refer to the above policy and complete following form prior to referral and provide evidence to support the criteria.

To Consultants: Please complete the box below and ensure there is evidence that the criteria are met.

WSCCG will only fund level 2** subfertility treatment when the following criteria are met

In ordinary circumstances, referral should not be considered unless the patient meets **all** of the following criteria.*

Maternal BMI is greater than 19 kg/m^2 and less than 30 kg/m^2	Y/N
Maternal age is more than 23 and less than 42 years	Y/N
Paternal BMI is less than 30 kg/m^2	Y/N
Paternal age is more than 23 and less than 55 years	Y/N
Where either or both partners smoke they have agreed to take part in and completed a recognised supportive smoking cessation programme	Y/N
Initial investigations have been initiated in primary care (semen test, blood tests determine ovulation and lifestyle advice) *for further information please refer to NICE clinical guidance 156*	Y/N

Version No	Updated by	Date updated
2.1	V Stearn	Feb 2017

Neither partner has undergone sterilization in the past	Y/N
There are no concerns regarding the welfare of the unborn child in accordance with the Regulatory Authority for Fertility and Tissue Guidelines.	Y/N
Both partners must be registered with a GP Practice within the CCG and be eligible for NHS care for at least 12 months prior to referral from primary to secondary care.	Y/N

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to I&ES CCG and WSCCGs' Individual funding request policy for further information.*

*** Level 2 services:Secondary and specialist care – provided in hospital; specialist investigations, drug treatment and monitoring at a higher level than in primary care Level 1. For Level 3 services please refer to the separate policy covering this service*

Consultant Use:

Please complete the following and file for future compliance audit.

Referral criteria is met and the patient will benefit from the proposed treatment: Y/N

Signature……..

Date: ___/___/___

Consultant Name:

Institution:

GP Use Only:

Practice Stamp/Address:

Referring Clinician _____

Date: ___/___/___

For Commissioners Use:

Criteria met as per policy Y/N

Compliance with notes Y/N

Audit Date:

Audited by: