National Referral Form for AHR Treatment

(Heterosexual couples)

Section 1: Referring Consultant Details

Name	
MCN	
Phone Number	
Referring Regional Fertility Hub	
Date of Referral	

Section 2: Personal Information

	Patient Details	Partner Details
UAN Reference Number for Female patient		UAN Not Applicable
Name		
Sex (M/F)		
Hospital MRN		
Date of Birth		
Address		
Postcode		
Email		
Phone		
GP Name		
GP Address		

Section 3: Current Lifestyle

	Patient Details		Partner Details	
Smoking Status	☐ Yes	☐ No	☐ Yes	☐ No
Vaping Status	☐ Yes	☐ No	☐ Yes	☐ No
Alcohol Intake	☐ Yes	☐ No	☐ Yes	☐ No
Recreational Drug Use	☐ Yes	☐ No	☐ Yes	☐ No
If yes please give details				

Section 4: Patient Details & History

Patient Height		Patient Weight		BMI	
Duration of Infertility (months)		Menstrual Cycle Length			
Medical / Surgical History					
Current Medications					
Gynae History					

Previous Lletz/cone biopsy		☐ Yes	☐ No
If yes;	Is cervix suitable for IUI/ET	☐ Yes	☐ No
	Is cervix suitable for pregnancy (likely competent)	☐ Yes	☐ No

Obstetric History				
Livebirth/SB/NND	Month and Year	Gestation at delivery	Type of Delivery (Vag/CS)	Conceived with current partner
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No

Miscarriage	Month and Year	Gestation	Conceived with current partner	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No
Termination of Pregnancy			☐ Yes	☐ No
Ectopic Pregnancy			☐ Yes	☐ No

Previous AHR treatment (IUI or IVF/ICSI) undertaken			☐ Yes	☐ No
Type:	IUI ☐	IVF/ICSI ☐	Number of cycles:	
If yes, attach clinical discharge summary from relevant AHR provider				

Section 4: Patient Details & History (continued)

Obstetric Complications and Risk Factors

Rubella Immune	*please tick*	☐ Yes	☐ No	
Varicella immune	*please tick*	☐ Yes	☐ No	
*Known history of hepatitis	*please tick*	☐ Yes	☐ No	*If yes, enclose result*
*Known history of HIV	*please tick*	☐ Yes	☐ No	*If yes, enclose result*
*Known history of Syphilis	*please tick*	☐ Yes	☐ No	*If yes, enclose result*

*Refers to patient's history only – all patients will not have been tested at this stage

Other Relevant Information

Section 5: Partner Details & History

Previous Paternities conceived with another partner	☐ Yes *If yes, please specify*	☐ No
Medical / Surgical History		
Current Medications		

Previous urogenital surgery	*please tick*	☐ Yes	☐ No	

Other Relevant Information

*Known history of hepatitis	*please tick*	☐ Yes	☐ No	*If yes, enclose result*
*Known history of HIV	*please tick*	☐ Yes	☐ No	*If yes, enclose result*
*Known history of Syphilis	*please tick*	☐ Yes	☐ No	*If yes, enclose result*

*Refers to patient's history only – all patients will not have been tested at this stage

Section 6: Current Fertility Diagnosis

Please list diagnosis as 1, 2 or 3 where 1 is the diagnosis most likely to be adversely impacting fertility

Unexplained		PCOS	
Endometriosis I-II		Anovulation other	
Endometriosis III-IV		Male factor mild (suitable IUI or IVF)	
Tubal mild (one tube normal)		Male factor severe (need ICSI)	
Tubal severe (bilateral salpingectomy, severe PID)		Cervical	
Hydrosalpinx (if yes details eg if clipped)		Psychosexual	

Other	

Section 7: Investigations and Treatment at Hub

Please tick Yes to investigations undertaken and provide associated reports as part of referral

Semen Analysis	☐	TFTs	☐
Ultrasound inclusive AFC	☐	Other Endocrinology Bloods	☐
AMH	☐	Other;	

Please list and provide details of treatment delivered by the regional fertility hub; (and attach computer print-out if applicable)

Section 8: Treatment Required

Treatment	**Select Only One**	**Number of Cycles**
IUI	☐	1 ☐ 2 ☐ 3 ☐
IVF*	☐	
ICSI*	☐	
ICSI plus TESE	☐	
FET^	☐	

* IVF or ICSI cycle includes fresh cycle and frozen transfers from that cycle until livebirth achieved or all embryos used

^ FET cycle includes any frozen transfers from the funded fresh cycle until livebirth achieved or all embryos used

IUI: referring doctor's suggestion for stimulation

Section 9: Multiple Pregnancy Minimisation

IUI	Cycle to be cancelled as per HSE guidance and requirements in the area of multiple birth minimisation.	☐
	IUI contra-indicated if more than one follicle in view of medical /obstetric history and is not to be pursued under any circumstances.	☐
IVF/ICSI/FET	Suitable for SET or DET as per HSE guidance and requirements in the area of multiple birth minimisation.	☐
	DET is contra-indicated in view of medical / obstetric history and is not to be pursued under any circumstances.	☐

Section 10: Details Regarding Any Specific Needs or Assistance Requirements Identified (eg mobility, literacy, language issues)

Section 11: Declaration and Signature by Referring Consultant

I _____ (Consultant Name) declare that, to the best of my knowledge,

_____ and _____ (Patients Name)

- has been fully assessed to progress for assisted reproductive services.
- are currently medically fit to undergo the treatment package for which they are being referred.
- have been advised of the package of care for which they are being referred and
- I have obtained their written consent to proceed with their referral to their chosen service provider.

SIGNATURE: _____

DATE _____

Checklist

- Patient Consent completed ☐
- UAN referral completed and accepted by provider ☐
- Copy of Blood results attached ☐
- Semen Analysis report attached ☐
- Copy of investigations reports attached ☐
- Discharge Summary regarding previous AHR treatment attached ☐