

Duration of Infertility	
Pregnancies as a couple (include dates and outcomes)*	
Menstrual cycle details	Average cycle length:

*Provide details on a separate sheet if necessary

	Female Partner	Partner
Pregnancies with previous partners (include dates and outcomes)*		
Any previous STIs*		
Other relevant medical history*		
Medication(s)* (Please ensure taking folic acid)		
Allergies*		
BMI	Ht: Weight: BMI:	(Only if overweight)

Required Investigations -The following investigations must be completed prior to referral and any results attached. If the female partner is oligo or amenorrhoeic please prescribe medroxyprogesterone acetate 10mg b.d. for 7 days to induce a withdrawal bleed in order to get an accurate profile for day 2 of menstruation (Progesterone levels may be omitted if cycles are very long)

	Result	Date
Day 21 Progesterone (Mid luteal if not regular cycle)	Indicate day if not D21	
Day 2 FSH / LH / E2	FSH LH E2	
Rubella	Antibody Detected / Not Detected (if not, please arrange immunisation)	
Chlamydia Screen	Negative / Positive	
Last Cervical screen	Negative / Abnormal (if so give details)	
Semen Analysis (Attach copy of report) Repeat only if 1 st abnormal.	Count: Motility: Morphology: Count: Motility: Morphology:	

The following tests may be completed if patient is oligo/amenorrhoeic, or if clinically indicated		
	Result	Date
Prolactin		
TSH		
Testosterone		

For office use only				
Date Received		Accept /Reject	To see	Consultant/Nurse

Comments:

SUBFERTILITY REFERRAL FORM- BARNSELY RESIDENTS

APPENDIX A

(please tick box OR fill in details)

HISTORY EXAMINATION AND INVESTIGATION OF THE FEMALE PARTNER

Date or referral ___/___/___ General Practitioner _____
 Surname _____ Forenames _____
 Date or Birth ___/___/___ Hospital No. _____
 Address _____

HISTORY OF THE FEMALE		
Duration or Infertility _____ (mths)	Primary <input type="checkbox"/>	Secondary <input type="checkbox"/>
Length Menstrual Cycle _____ (days)	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/> Amenorrhoea <input type="checkbox"/>
Abnormal bleeding	None <input type="checkbox"/>	Between Periods <input type="checkbox"/> Post coital <input type="checkbox"/>
Past medical History	None <input type="checkbox"/>	Details _____
Past Surgical History	None <input type="checkbox"/>	Details _____
Past Gynae History	None <input type="checkbox"/>	Details _____
Past Obstetric History	None <input type="checkbox"/>	Details _____
History of STD	None <input type="checkbox"/>	Details _____
Medication'	None <input type="checkbox"/>	Details _____
Smoking	None <input type="checkbox"/>	Number/day _____
Alcohol	None <input type="checkbox"/>	Units /week _____

EXAMINATION OF THE FEMALE		
BMI Body Mass Index	_____	Blood Pressure ___/___
CVS/RS Examination	Normal <input type="checkbox"/>	Details _____
Abdominal Examination (scars)	Normal <input type="checkbox"/>	Details _____
Pelvic Examination	Normal <input type="checkbox"/>	Details _____
INVESTIGATION OF FEMALE		
Date or last Smear ___/___/___	Normal	Details _____
Rubella	Immune	Date Immunised ___/___/___
Haemoglobin	_____	
Hormone Assay Result	FSH _____	LH _____
Progesterone (specimen should be taken 7-10 days before next period)		
	Result _____	Date or Next Period ___/___/___

COMMENTS _____

