Assisted Conception Service, Glasgow Royal Infirmary	NHS Greater Glasgow and Clyde

S-Form-177 Fertility Preservation Referral

Document number: S-FORM-177	Version 5

To be completed by the referrer and emailed to preservation.acs@ggc.scot.nhs.uk :

Criteria for NHS Treatment

Please confirm that the patient meets the following criteria:

- Storing eggs or embryos: is the patient's BMI under 35? YES / NO / NA
- If storing eggs/embryos, is the patient 37 years old or under? YES / NO / NA
- If storing sperm, is the patient 55 years old or under? YES / NO / NA
- Does the patient have existing biological children/is a legal parent? YES / NO
- Has the patient been previously sterilised? YES / NO
- Is the chance of fertility lost though therapy estimated to be >50%? YES / NO
- Oncology: is treatment is with intention to cure? YES / NO / NA

If NHS funding criteria are not met, does the patient wish to consider self funded storage? YES / NO

COVID-19 Restrictions

During the current COVID-19 pandemic, referrals will only be accepted for patients who are at the greatest risk of impairment of fertility due to radiotherapy or chemotherapy as a result of cancer or chemotherapy for a serious systemic disease.

Referrals will only be accepted for patients who do not have symptoms of COVID-19.

Referrals will only be accepted for patients who are medically fit and well to attend a hospital environment and undergo the treatment required to facilitate storage of eggs/embryos/sperm.

Please confirm that the patient meets the following criteria:

- The patient does not have a fever (over 37.8^{o}C) YES / NO
- The patient is not coughing at present YES / NO
- The patient does not have a sore throat YES / NO
- The patient has not lost sense of smell or taste YES / NO
- The patient has not been in contact with a person with COVID-19 symptoms YES / NO
- The patient has not been in contact with a person who has COVID-19 YES / NO
- The patient has not been diagnosed with COVID-19 YES / NO
- The patient is medically fit and well to undergo fertility preservation YES / NO

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PLEASE INFORM PATIENT TO BRING PHOTOGRAPHIC ID TO THE ACS UNIT- REQUIRED FOR STORAGE OF GAMETES/EMBRYOS

Patient Details

Patient Name:	**CHI:**
Address and Postcode:	**Ethnicity:** 1 White British 2 White Irish 3 Any other white background 4 White and Black Caribbean 5 White and Black African 6 White and Asian 7 Any other mixed background 8 Black Caribbean 9 Black African 10 Other black background 11 Chinese
Phone number for patient:	
Current age: / **BMI:**	
Confirm patient is post-pubertal: YES / NO / **Relationship status:**	
Reason for referral to fertility preservation service: 1 Cancer 2 Non-cancer medical reason 3 Transgender 4 Armed forces 5 Other	**Date of referral to fertility preservation service:** **Date of diagnosis:**
Type of cancer (ICD code): C18 Colon C40 Bone and articular cartilage – limbs only C41 Bone and articular cartilage - non-limb/ not specified C50 Breast C53 Cervix uteri C56 Ovary C62 Testis C71 Brain/CNS C81 Hodgkin lymphoma C82 Non-Hodgkin lymphoma – follicular lymphoma C83 Non-Hodgkin lymphoma – non-follicular lymphoma C84 Non-Hodgkin lymphoma – mature T/NK-cell lymphoma C85.9 Non-Hodgkin lymphoma – unspecified C91 Lymphoid leukaemia C92 Myeloid leukaemia	**Type of medical condition (ICD code):** M32 Systemic Lupus Erythematosus M05 Rheumatoid arthritis – seropositive M06 Rheumatoid arthritis – other M07 Psoriatic and enteropathic arthropathies M45 Ankylosing Spondilitis G35 Multiple sclerosis D56 Thalassaemia D57 Sickle cell disorders D60 Acquired pure red cell aplasia D61 Other aplastic anaemias (including Fanconi anaemia) K50 Crohn's Disease K51 Ulcerative Colitis N80 Endometriosis Q96 Turner Syndrome Q99.2 Fragile X E74.2 Galactosaemia
Planned treatment: 1 Surgery 2 Radiotherapy 3 Chemotherapy 4 Radiotherapy and chemotherapy 5 Surgery and chemotherapy 6 Surgery and radiotherapy 7 Surgery, radiotherapy and chemotherapy	**Predicted reduction in fertility after current planned treatment:** <10% 10-30% 30-70% >70% Unknown
Any previous chemotherapy: Yes No	**Referrer details** Name: Position: Hospital & dept: Contact details:

S-Form-177 Fertility Preservation Referral

To be completed by the fertility clinic:

Patient Details

Patient Name:	**CHI:**
Address and Postcode:	**Funding:** NHS Self-funded
Agreed on CD form for: 1 Auditors and admin staff outside the clinic 2 Non-contact research 3 Contact research	**Date of preservation:**
Outcome of fertility preservation: 1 Consultation only 2 Proceed with storage	**Type of cryostorage:** 1 Egg 2 Embryo 3 Egg and embryo 4 Ovarian tissue 5 Sperm 6 Testicular tissue

Cryostorage Details

Sperm

Number of ejaculates stored:

Eggs/Embryos

Number of eggs stored:

Number of embryos stored:

Basal AMH:

Basal FSH:

Smoker status:
Never smoked
Ex-smoker
Current smoker

BMI (female):

Previous pregnancy:
Yes
No