

**Standard Referral Proforma for Assisted Conception Treatment**  
 (Please complete this form fully)

Please send to:

Mr Yakoub Khalaf, Medical Director  
 Assisted Conception Unit  
 11<sup>th</sup> Floor, Tower Wing  
 Guy's Hospital, Great Maze Pond  
 London, SE1 9RT

Name of Referrer:

Source of Referral: Hospital / GP

**Section A: Patient details**

*Female partner:*

Surname: .....

First name: .....

Date of birth: .....

Address: .....

.....

.....

Postcode: .....

Tel: (home) .....

Tel: (work) .....

Tel: (mobile) .....

Female weight ..... kgs

Female height ..... m

*Male Partner:*

Surname: .....

First name: .....

Date of birth: .....

Address:- Same as female partner?

Yes / No

If different:- .....

.....

Post code: .....

Tel: (home) .....

Tel: (work) .....

Tel: (mobile) .....

Length of time in relationship ..... yrs

Length of time trying to conceive ..... yrs

**Section B: GP & Hospital details**

GP Name: .....

Consultant: .....

Address: .....

Hospital: .....

.....

Address: .....

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.....

.....

.....

Postcode: .....

Postcode: .....

Telephone: .....

Telephone: .....

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**SECTION C: Relevant medical history**

1. Significant medical & drug history:

<i>Female partner:</i>	<i>Male partner:</i>
Medical history	Medical history
Drugs	Drugs

2. Previous pregnancies:

Female partner: YES / NO	Male partner: YES / NO / SAME AS FEMALE				
If YES, please give details:	If YES, please give details:				
Year	Gestation	Outcome	Year	Gestation	Outcome

3. Investigations for subfertility: (please either enter results or forward copies of results)

Test	Date	Result	Test	Date	Result
FSH (day 2-4)			Progesterone		
LH			Rubella		
Oestradiol			Cervical smear		
Prolactin			Sickle status		
Testosterone					

Ultrasound scan dated: \_\_\_\_\_

Tubal patency:

Date	Lap and Dye/Hysteroscopy results	Date	HSG results
	Uterine cavity normal? YES / NO		Uterine cavity normal? YES / NO
	Right tube patent? YES / NO		Right tube patent? YES / NO
	Left tube patent? YES / NO		Left tube patent? YES / NO
	Pelvis normal? YES / NO		
If abnormal, please give details:			

Semen analysis:

Date	Volume (ml)	Count (M/ml)	Motility (%)	Normal morphology

Previous fertility treatment:

Treatment, eg IVF	Where?	When?	How many cycles?	Outcome?