Edinburgh Fertility Centre

Fertility Preservation
Referral Form

1. Referrer information

Date of referral		Referring doctor	
Hospital/Dept			
Phone number		Email	

2. Patient information

First name					
Surname					
Address					
				Postcode	
DOB		CHI		Phone number	

Ethnicity		Type of preservation	☐ Eggs
Pronoun			☐ Sperm
Sexuality[1]			☐ Embryos

3. Eligibility for storage

For NHS funded storage, please confirm that the patient meets all eligibility criteria shown:

NHS funding
- ☐ Patient is resident in Lothian or Borders[2]
- ☐ Patient storing eggs/embryos has BMI under 35
- ☐ Patient storing eggs/embryos is <40 years old
  or Patient storing sperm is <53 years old
- ☐ Patient has no existing biological children/not the legal parent
- ☐ Patient has not previously undergone sterilisation or reversal of sterilisation
- ☐ Patient has an estimate >30% chance loss of fertility
- ☐ Wishes to have a biological family in the future

Self funding
- ☐ Patient does not meet the above criteria and wishes to self fund gamete/embryo storage

Fitness
- ☐ Patient is fit to travel to appointments at the Edinburgh Fertility Centre
- ☐ Patient is fit for procedures including anaesthetic/sedation
  or Patient is able to produce a sperm sample by masturbation

[1] Some patients may require additional screening due to potential future treatment needs.
[2] Patients from other health board areas require funding approval from board of residence before storage can commence.

4. Diagnosis

Reason for referral ☐ Cancer ☐ Non-cancer ☐ Transgender
☐ Other (please specify)

Type of condition (include ICD10 code)

Date of diagnosis | Date treatment starting/started (estimate)

Planned treatment (select all that apply)
☐ Chemotherapy ☐ Radiotherapy
☐ Surgery ☐ Contrast investigation
☐ Hormone therapy ☐ Other (please specify)

Please ensure patient understand the effects of treatment on gametes and recovery time if taking medication.

If chemotherapy, specify regimen

If pelvic radiotherapy, specify dose

If contrast investigation, specify dose | Date of scan

Predicted reduction in fertility after treatment ☐ <10% ☐ 10 to 30% ☐ 30 to 70% ☐ Unknown

Previous chemotherapy ☐ No ☐ Yes
If yes, date and regimen if known

Relevant medical history (e.g. ovarian cysts)

5. Additional information

Alcohol intake units/week

Smoking/vaping status ☐ Never smoked/vaped ☐ Ex-smoker / Ex-vaper ☐ Smoker / Vaper

Previous pregnancy/ fathered a child ☐ No ☐ Yes

Travelled overseas within the last 2 years? ☐ No ☐ Yes – Please provide dates and countries/regions

For egg/embryo storage referrals only:

Basal AMH, if known pmol/L | Basal FSH, if known IU/L | BMI kg/m^2

6. Medical practitioner's statement

I certify that the person named in Section 2 of this form is, or is likely to, become prematurely infertile.

Name (print) | Signature* | Date

*Signature not required if emailed directly from named GMC medical practitioner

Submission of referral

Please note that all sections are required unless otherwise specified. Incomplete referrals will not be actioned.

Egg/embryo storage	Completed forms should be submitted to loth.assistedconceptionunit@nhs.scot and immediately followed up with a phone call to 0131 242 2450 or 0131 242 2446
Sperm storage	Completed forms should be submitted to loth.rmlenquiries@nhs.scot. Please phone 0131 242 2463 to discuss urgent referrals