

Female Patient Registration



PLEASE WRITE CLEARLY IN
BLACK INK USING BLOCK CAPITALS

Centre:

Form R:

1. What this form is for

Is registering a new patient: Replaces all details previously registered:

Is notifying corrections to form R: (if applicable)

Form completion date:

Date patient first registered at this clinic:

A Donor Information Form must also be submitted if the patient is an Egg Donor.

2. Patient details

Female patient number: Donor number (if applicable):

Previous patient number (if changed):

Patient first name(s): Patient surname:

First name(s) at birth: (if different from above):

Surname at birth: (if different from above):

Date of birth: Gender:

Place of birth: Country of birth:

NHS Number for UK resident (if known):

OR

Passport/ID Card Number: Country of issue:

Is the patient disabled? Yes No

Patient ethnic group:

Please see guidance notes for current list of ethnicity codes

Has this person travelled from overseas for treatment in the UK? Yes No

Does the patient currently have a partner? Yes No

(if yes, please complete a Partner Registration Form)

3. Patient/donor previous obstetric history

Please note the total number of:

previous natural pregnancies

natural live births

previous IVF pregnancies

IVF live births

previous DI pregnancies

DI live births

Duration of infertility (years):

4. Cause of infertility

Cause of female infertility/reason for treatment (more than one may apply)*

tubal disorders

endometriosis

uterine problems

menopausal

ovulatory disorder (inc. PCO)

ovarian failure

avoidance of genetic disorder

male factor

no male partner

unexplained

other

Last UK clinic for a new patient/donor treated elsewhere (if known):

5. Consent for researchers

Generic consent for research

Yes

No

Consent for non-contact research

Yes

No

Consent for contact research

Yes

No