

WELFARE of the child:**PENINSULAR FERTILITY NETWORK**

Patient history form

This form should be completed by each patient requesting any treatment from a center operating as part of the Peninsular Fertility Network. For further information, please refer to the HFEA Code of Practice Part 3 (revised 2005)

The information you provide in this form will help determine whether any child you might have is likely to be at risk of serious harm. Decisions are made on a case by case basis. How you answer will not necessarily mean that treatment will be refused. For further information about the welfare of the child assessment please refer to www.hfea.gov/ForPatients

Woman's name.....

Date of birth.....

Town and country of birth...

Details of pregnancies and births with current partner.....

Details of pregnancies and births with any previous partner....

Year of last pregnancy (if applicable)

Husband or partner's name.....

Date of birth.....

Town and country of birth...

Details of pregnancies and births with current partner.....

Details of pregnancies and births with any previous partner....

Year of last pregnancy (if applicable)

Contact address:

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|---|-----|--------------------------|----|--------------------------|
| 1. Do either of you have any previous convictions relating to harming children? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Have any child protection measures been taken regarding your children? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Is there any serious violence or discord within your family environment? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Do either of you have any physical or psychiatric illnesses? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. To you knowledge is your child at increased risk of any transmissible or inherited disorders? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Do either of you have any drug or alcohol problems? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. Are there any other aspects of your life or medical history which may pose a risk of serious harm or impair your ability to care for any child you might have? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If the answer to any of the above questions is yes please give details:

8. How long have you been together/married?.....

9. How long have you been trying for this baby?.....

10. Do you both intend to take full legal responsibility for a child born to you as a result of treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Please indicate in signing the form that you believe the above information to be accurate and that you have received and been asked to read a copy of the clinic's information leaflet 'What to expect at the Exeter Fertility Clinic 0509 v1.3', which can also be viewed at www.fertilitypc.com

Woman's signature and date....**Husband or partner's signature and date**...*To be completed by the center*

Further information sought? If yes, specify: a) grounds for seeking information; b) type of information sought; and, c) source of information. Detail response(s) and any further action to be taken on an appended sheet.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Treatment offered? If no, give grounds for refusal and any steps patient(s) could take to reconsider the decision	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>