Locala Sexual health

EXTERNAL AGENCY REFERRAL INTO STOCKPORT SEXUAL HEALTH SERVICE

Return completed form to: lcp.ha.choices@locala-cic.nhs.uk

DATE & TIME OF REFERRAL Click here to enter a date. **Time:** Click or tap here to enter text.

REFERRING AGENCY	REFERRER'S NAME & ROLE
Click here to enter text.	Click here to enter text.
CONTACT NUMBER	**E-MAIL ADDRESS**
Click here to enter text.	Click here to enter text.
ADDRESS OF REFERRING AGENCY	Click or tap here to enter text.

Please confirm the service user has consented to this referral

Yes ☐ No ☐

FULL NAME	Click here to enter text.	
DATE OF BIRTH	Click or tap to enter a date.	
CURRENT ADDRESS	Click here to enter text.	
LAC?	Yes ☐	No ☐
CONTACT NUMBER	Click here to enter text.	

DISABILITY	PREFERRED GENDER	SEXUALITY	RELIGION
Choose an item.	Choose an item.	Choose an item.	Click here to enter text.
ETHNICITY (Ethnic category 2011 census)			
Choose an item.			

PREFERRED METHOD OF CONTACT **please enter the preferred way to contact the individual being referred**	
Phone contact with Patient directly	**Yes ☐ No☐**
Can we leave a voicemail	**Yes ☐ No☐**
Can we send text messages	**Yes ☐ No☐**
Send correspondence to patients address	**Yes ☐ No☐**
Phone contact with allocated worker	**Yes ☐ No☐**
If yes and different to Referrer, please give details below:	
Name:	Click here to enter text.
Role:	Click here to enter text.
Contact numbers:	Click here to enter text.

Does this patient require an interpreter? Yes ☐ No ☐
If yes, Please state language Click here to enter text.

REASON FOR REFERRAL include details of additional vulnerabilities
Click or tap here to enter text.

Please complete second page of referral….

DETAILS OF INFECTIONS	
Infection Name	**Chlamydia** Yes ☐ No☐
	Gonorrhoea Yes ☐ No☐
	TV Yes ☐ No☐
	HSV Yes ☐ No☐
	BV Yes ☐ No☐
	Hepatitis B Yes ☐ No☐
	HIV Yes ☐ No☐
	Syphilis Yes ☐ No☐
Date of Testing	Click here to enter a date.
Site of infection (if applicable)	Click here to enter text.
Treatment details (if applicable)	Click here to enter text.

REFERRAL FOR LONG ACTING REVERSIBLE CONTRACEPTION (LARC)	
LARC **Please tick type of LARC requested and reason for referral below**	**IUD insertion** ☐ removal ☐
	IUS insertion ☐ removal ☐
	Implant insertion ☐ removal ☐
	STI screening completed Yes ☐ No☐
	Counselled about method Yes ☐ No☐
Reason for referral	**Lost threads**
Current contraception	Click here to enter text.
Other relevant information	Click here to enter text.

PLEASE GIVE DETAILS OF ANY OTHER AGENCIES INVOLVED WITH THIS PERSON		
Agency	**Contact Name & Role**	**Contact Numbers/ e-mail**
Click here to enter text.	Click here to enter text.	Click here to enter text.
Agency	**Contact Name & Role**	**Contact Numbers/ e-mail**
Click here to enter text.	Click here to enter text.	Click here to enter text.
Agency	**Contact Name & Role**	**Contact Numbers/ e-mail**
Click here to enter text.	Click here to enter text.	Click here to enter text.

Please send referral to lcp.ha.choices@locala-cic.nhs.uk

****Please send this form from a secure (nhs.net) e-mail address****

END OF REFERRAL FORM