**Sexual Health Referral Form**

Part 1: Services available and information to be included in referral form

Part 2: Which service are you referring to?

Part 3: Client details and reason for referral

*Please ensure all sections of part 2 and 3 are completed before sending referral*

Please email all referrals to: **Snhs.sexualhealthreferral@nhs.net**

Please note clients requesting urgent help (E.g. emergency contraception, PEPSE, suspected first outbreak of HSV, post sexual assault screening or new HIV diagnosis) can call our Single Point of Access on 0300 300 2016 for further advice or to book an appointment.

We recommend that GPs also use this number to arrange a specialist HIV appointment to be given to patients at time of diagnosis.

Not all services are available at all sites

For urgent SARC referrals (assault within the forensic window) please call the SARC team on 0300 123 6616.

Appointments can be booked online by clients at

[www.letstalkaboutit.nhs.uk](http://www.letstalkaboutit.nhs.uk)

**Due to the Covid-19 pandemic initial contact with the patient may be by telephone. Please supply preferred telephone number.**

**Part 1: Services available and information to be included in referral form**

**Outreach Nursing service**

For at risk clients who are unable to attend clinics with a view to facilitating their eventual attendance at clinic.

*In reason for referral, please be as specific as possible. Why is this client vulnerable and unable to attend clinic? What are their contraceptive and sexual health needs? Are there any safety issues around lone working with this client?*

**Sexual Health Promotion Team**-

Provides 1:1 support/motivational interviewing for individuals engaged in risky sexual behaviours and therefore at increased risk of unplanned pregnancy, sexual exploitation or sexually transmitted infections including blood borne viruses. Clients must be prepared to engage with a behaviour change programme.

*In reason for referral, please be as specific as possible explaining your reasons for selecting each risk factor. We may have to contact you if we need more information before we can proceed.*

**Complex GUM or Sexual and Reproductive Health** –

For insertion / removal of difficult coils, difficult / deep implant removals, ultrasound for complex contraception, not responding to STI treatment, persistent symptoms, syphilis diagnosis. **Please note, Sexual Health Services are** *NOT* **commissioned to provide contraception (including the IUS) as a method of period control or as the progestogen component of HRT**

*In reason for referral, please be as specific as possible and include any relevant medical history including details of current medication.*

**HIV Services**

For new HIV diagnosis and transfer of HIV Care into area or HIV care queries.

*In reason for reasons for referral, please be as specific as possible and include all other HIV queries or relevant information*

**Sexual Assault Referral Centre**

For non-urgent referrals following sexual assault (outside the forensic window)

*In reason for referral, please be as specific as possible and include as much information as you can.*

**Part 2: Which service are you referring to?**

|  |  |
| --- | --- |
|  |  |
|  |  |
| **o** | **Outreach Nursing service***Please tick relevant box below:* |
|  |

|  |  |
| --- | --- |
| Post termination, contraception follow up Under 19 |  |
| Midwife referral, contraception follow up post-delivery under 19 |  |
| Contraceptive and Sexual Health care for a vulnerable client who is unable to attend mainstream services |  |

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|  |  |
| **o** | **Sexual Health Promotion Team***Please tick risk factors below:*

|  |  |  |  |
| --- | --- | --- | --- |
| Multiple Sexual Partners |  | Repeat STI diagnosis |  |
| Unprotected Intercourse |  | HIV Positive |  |
| At risk of Pregnancy (U18) |  | At risk of HIV and other STIs |  |
| Not Using Contraception Effectively |  | Repeat Emergency Contraception |  |
| Unprotected Intercourse (no condom) |  | Sexually active at early age |  |
| LGBT+ |  | Learning Difficulty |  |

Other Risk Factors- tick those that apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sexual Risk Taking |  | Suicidal Thoughts |  | Violence |  |
| Relationships |  | Mental Health/ Depression/ Anxiety |  | Drugs/ Chemsex use |  |
| Domestic/Partner Violence |  | Self-Harm |  | Alcohol misuse |  |
| At risk of sexual exploitation |  | Exploring sexuality |  | Exploring gender identity |  |
| Teenage Parent |  | History of Termination |  | Risk of FGM |  |
| Older Partner |  | Risk of Grooming/sexual exploitation |  | Missing, Exploited, Trafficked History |  |

[ ] Tick if client is willing for 1:1s to be completed via online video link |
|  |  |
|  |  |
| **o** | **Complex GUM or Sexual and Reproductive Health** *Please tick relevant box below:* |
|  |

|  |  |
| --- | --- |
| Lost IUCD threads |  |
| Pain/bleeding with IUCD in situ |  |
| Pain/bleeding on any other form of contraception |  |
| Difficult IUCD removal |  |
| Difficult IUCD insertion |  |
| Deep/difficult implant removals |  |
| Complex contraception |  |
| Not responding to STI treatment /persistent symptoms |  |
| Syphilis diagnosis |  |

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|  |  |
| **o** | **HIV Services** *Please complete relevant information below:*

|  |  |
| --- | --- |
| New diagnosis |  |
| Date of diagnosis |  |
| Patient aware of diagnosis (please tick) | Yes |  | No |  |

|  |  |
| --- | --- |
| **Transfer of Care** |  |
| Date of diagnosis (if known) |  |
| Date of transfer |  |
| Current medication |  |
| Latest viral load and cd4 counts |  |

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|  | [ ] Tick if we can contact the patient directly using details you have provided |
| **o** | **Sexual Assault Referral Centre***Please complete relevant information below:* |
|  |

|  |  |
| --- | --- |
| Date of alleged assault |  |
| Police aware? (please tick) | Yes |  | No |  |
| Safeguarding issues considered and reported? (please tick) | Yes |  | No |  |

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**Part 3: Client details and reason for referral**

*\*Denotes mandatory information. Referrals will not be accepted without this information.*

**Referrers Details**

|  |  |
| --- | --- |
| Name\* |  |
| Organisation\* |  |
| Address/Postcode |  |
| Telephone Number\* |  |
| Email Address |  |
| Date of referral\* |  |

**Client details**

|  |  |
| --- | --- |
| Name\* |  |
| Date of Birth\* |  |
| Address\* |  |
| Gender at Birth |  |
| Gender Identity |  |
| Sexual Orientation |  |
| Safe Contact Phone Number\* |  |
| Client Email Address |  |
| Preferred Method of Contact (phone/email/letter/text) |  |
| GP Name and Address\* |  |
| Consent for Referral (yes/no)\* |  |
| Any Accessible Information Needs |  |
| Other Agencies Involved |  |

|  |
| --- |
| **Reason for referral (see part one for information to be included)** \* |
|  |

|  |
| --- |
| **If applicable, are there any known risks to visiting this patient?** \**If yes, please provide further details:* |
|  |