**Primary Care**

**Urgent Referral Form**

This form is for completion by Primary Care colleagues, across **Oldham, Rochdale and Bury**, to refer patients from their practice who have positive test results for **gonorrhoea / syphilis or HIV, or** who require an **IUD (copper coil) for emergency** contraception, into the specialist sexual health service. This form should be completed by a registered professional.

We aim to contact your patients **within 48 hours of a referral** (or the next working day if this is a bank holiday or weekend) appropriate to the reason for referral.

Please inform the patient that we will contact them by phone and to be aware the call will be from an unknown number. By agreeing to the referral, patients agree that we can contact them by phone (call or text) *or email / post as a last resort.*

**For positive gonorrhoea, syphilis, and emergency IUD**

To discuss the referral, contact one of our clinical team on the relevant mobile number during our clinical opening hours. If the clinician is unavailable to take your call, please leave a voicemail and we will return your call as soon as possible.

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|  |  |  |
| **Oldham** | **07554 1145 06** | |
| **Rochdale** | **07554 114 514** | |
| **Bury** | **07554 114 527** | |

Please note that we still require a completed referral form to be sent via email to one of the email addresses below. If we are unavailable at the time of your call, please leave a voicemail and send referral form without delay.

To refer via email:

* Fill in the referrer details.
* Confirm that the patient has consented to be contacted by the specialist sexual health clinic.
* Complete the patient demographic details, including reason for referral \*
* Email with subject header: URGENT REFERRAL to:

[**hcrg.vcl.orbish@nhs.net**](mailto:hcrg.vcl.orbish@nhs.net)

**For positive HIV referral**

MFT provide treatment and care for HIV in Oldham, Bury and Rochdale.

Phone 0161 720 2637 or 0161 720 2638

Or email: HIV.teamnmgh@mft.nhs.uk

* ***This referral process is for urgent referrals only; patients referred for any other reasons will not be contacted or booked an appointment.***

For all other sexual health service information, please visit: [Find Sexual Health Advice & Clinics Near You | HCRG Care Group (thesexualhealthhub.co.uk)](https://www.thesexualhealthhub.co.uk/)

**Referral from (to be completed and sent via email)**

**Referrers details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Professionals Name |  | | |
| Address / Practice |  | | |
| Date of referral |  | I confirm that the patient has consented to be contacted by the sexual health service (X) |  |

**About the patient:**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth |  |
| Address |  |
| Contact Telephone Number |  |
| Email address |  |

**Reason for Referral (X where appropriate):**

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency IUD |  | Positive Gonorrhoea Test |  |
| Positive HIV Test |  | Positive Syphilis Test |  |

Please provide any further relevant details (date/details of STI test/result/symptoms/medications/ accessibility needs.

V2: August, 2025