REFERRAL TO COVENTRY & WARWICKSHIRE SEXUAL HEALTH HUB

Patient Details:				**Referrer Details:**	
Name:				Name:	
Address:				Phone:	
				Email:	
				Referrer Org:	
Postcode:				Referrer /Practice Address:	
DOB:					
Phone:					
Contact Permissions:		Phone	Y / N		
		Voicemail	Y / N	Postcode:	

I confirm that the patient has consented to be contacted by the Sexual Health Service	**Y / N**

Reason for Referral - Please check all that apply:			
Contraception		Positive HIV Test	
Complex LARC		Positive Syphilis Test	
Vulnerable Child (<18)		Positive Gonorrhoea Test	
Vulnerable Adult (18+)		Psychosexual Counselling	
Vasectomy		Other (please detail below)	

Please note that due to funding we are unable to insert IUS for gynaecological reasons alone e.g. postmenopausal endometrial protection or heavy menstrual bleeding or in a patient who has been sterilised - these patients require a gynaecology referral.

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

Please outline any safety or safeguarding issues that may apply, and that our team may need to be aware of.

Date of Referral:	

Please complete this form as fully as possible. If form is insufficently completed the referral may be rejected. Patients will be contacted by Coventry & Warwickshire Sexual Health Hub to arrange an appointment once the referral has been received and triaged.

Please send all completed referrals to hcrg.cwsexualhealthhub@nhs.net.