

**EXTERNAL AGENCY REFERRAL INTO**

**BRADFORD SEXUAL HEALTH SERVICE**

LCP.healthadvisorgroupsecure@locala.org.uk

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

Click here to enter text.

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| **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. |

**Please confirm the service user has consented to this referral**

**Yes** [ ]  **No** [ ]

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| **FULL NAME** | Click here to enter text. |
| **DATE OF BIRTH** | Click here to enter text. |
| **CURRENT ADDRESS** | Click here to enter text. |
| **LAC?** | Yes [ ]   | No [ ]  |
| **CONTACT NUMBER** | Click here to enter text. |
| **NHS NUMBER** | Click here to enter text. |

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| **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. |

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| **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.

**Please complete second page of referral….**

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

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| **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. |
| **Date of delivery** (6wk coil check) | Click here to enter a date. |

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| **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.healthadvisorgroupsecure@locala.org.uk

**END OF REFERRAL FORM**