

**EXTERNAL AGENCY REFERRAL INTO**

**BRADFORD SEXUAL HEALTH SERVICE**

[LCP.healthadvisorgroupsecure@locala.org.uk](mailto:LCP.healthadvisorgroupsecure@locala.org.uk)

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

Click 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. |

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

**Yes  No**

|  |  |  |
| --- | --- | --- |
| **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](mailto:LCP.healthadvisorgroupsecure@locala.org.uk)

**END OF REFERRAL FORM**