

**SEXUAL HEALTH OUTREACH & PREVENTION REFERRAL FORM**

Please complete and return to:

Lcp.stockportoutreach@locala-cic.nhs.uk for Stockport Sexual Health

All referrals will be received by the Sexual Health Outreach and Prevention Team.

|  |  |
| --- | --- |
| **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. |

**DATE OF REFERRAL** Click here to enter a date.

# 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. |
| **CONTACT NUMBER** | Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **DISABILITY** | **PREFERRED GENDER** | **SEXUALITY** | **RELIGION** |
| Choose an item. | Choose an item. | Choose an item. | Click here to entertext. |
| **ETHNICITY (Ethnic category 2011 census)** |
| Choose an item. |

**REFERRAL CRITERIA**

People referred into the Stockport and Tameside Sexual Health Outreach & Prevention Team need to meet one or more of the following criteria:

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Affected by domestic abuse? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Affected by substance misuse? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Involved with Criminal Justice System? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| LAC with complex health & social issues? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Experienced sexual assault? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Previous/current involvement in the sex industry? (Adults only)  | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Mental health or emotional wellbeing support needs? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |  |  |
| --- | --- | --- |
|  |  | ***If yes, please give details…*** |
| Affected by Child Sexual Exploitation? | Yes ☐ | Click here to enter text. |
|  | No ☐ |  |

|  |
| --- |
| **SEXUAL HEALTH HISTORY** |
| Please give details of any previous involvement with service and/ orcontraception method, if known | Click here to enter text. |

|  |
| --- |
| **PLEASE PROVIDE INFORMATION IN SUPPORT OF THE REASON FOR THIS REFERRAL and****DETAILS OF CURRENT AGENCIES/ PROFESSIONALS INVOLVED** |
| Click here to enter text. |

DOES THIS CLIENT POSE A RISK TO THE WORKER? Yes ☐ No ☐