Appendix 1 – Referral Form

REFERRAL FORM TO: Contraceptive and Sexual Health Service

SECTION 1: To be completed by the Referral Agency – faxed to 01305 260 994

SERVICE USER INFORMATION				**REFERER INFORMATION**	
Name				Referral Agency	
D.O.B		Age		Telephone Number	
Mobile No				Fax Number	
Email				Current Contraception Method: Reason for EHC use:	
House number		Postcode			
Preferred contact method?	Text	Mobile	Email		
Service User consent to be contacted	Print Name: …… Signature: ……			Referral made by Clinician	Print Name: …… . Signature: ……

SECTION 2: To be completed by LARC Nurse

Date / method of 1st Contact		Outcome		Signature*:*	
Date / method of 2nd Contact		Outcome		Signature*:*	
Date / method of 3rd Contact		Outcome		Signature*:*	
Appointment Date		Time		Location	

SECTION 3: To be completed by C&SH Clinic and returned to 20 Trinity Street

Appointment Date		Time		Location	
Outcome ***(S)***		LARC Uptake?	Depo		
			Implanon		
			IUD		
			IUS		
Name		Signature		Date	

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