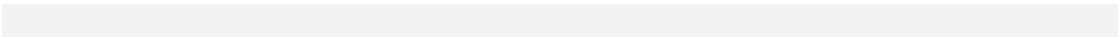


Appendix 1 – Referral Form

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	

**Contraception and Sexual Health Service, 20 Trinity Street Dorchester,
DT1 1TU.
Tel 0300 303 1948 Fax 01305 260 994**