OUTREACH SEXUAL HEALTH REFERRAL

Client Information	
Forename:	Hospital No:
Surname:	DOB:
Address: Post Code Permission for written correspondence YES / NO	Mobile number 1: Permission to text? YES / NO Permission for voicemail? YES / NO Other number 2: Permission to text? YES / NO Permission for voicemail? YES / NO

Criteria for Referral - we accept referrals from all professionals and are able to provide Contraception and Sexual Health care to vulnerable clients outside of a clinic setting	Please Tick ☑
Post termination , contraception follow up	
Postnatal, contraception follow up	
Clinical symptoms which require assessment and care	
Untreated infection which requires management from sexual health	
Sexual or reproductive health needs which require assessment and care	

Further information – please provide additional clinical details, any safeguarding concerns and additional needs or vulnerabilities identified (including challenging behaviour or conduct).

If the client has input from health or social care support agencies, please detail below		
Name	Agency	Email / telephone

Referrer Information	
Name:	Designation/Agency:
Email:	Contact number:

Office Use					
received		**Allocated to :**		**Date 1st contact**	