

Office Use Only	
Date of receipt	
Locality	
Referral Source	
Presenting Issue	

PB Number:
Additional Triage Form: YES / NO

PSYCHOSEXUAL SERVICE - SHARE REFERRAL FORM

PLEASE COMPLETE IN FULL AND BOTH SIDES

Acorn PHCC, 421 Blackburn Rd, Accrington BB5 1RT Tel: 01254 283333

Mobile: 07538475987 email bfw-tr.shareblacklancs@nhs.net

Date of Referral:
Name of Referrer (please print).....
Signature of Referrer:
(FULL) Address of Referrer:
.....Post Code.....Tel No.....
Registered GP details (if not referrer)
.....
.....
<u>Does the patient/client give consent for SHARE to contact their GP? YES / NO</u>

Patients Full Name:
Full Address:
.....
Post Code..... Tel No:
D.O.B: NHS No.....
Risk – Any Contact Restrictions – please state
.....
Ethnicity: (please circle) White British, White Other, Black-Caribbean, Black-African, Black-Other, Indian, Pakistani, Chinese, Bangladeshi, Other (please state)

PLEASE NOTE
REFERRALS ARE NOW ONLY RECEIVED DIRECTLY FROM GP'S, THE SEXUAL HEALTH SERVICE, SECONDARY CARE SERVICES ie Gynaecology, Urology, Endocrinology etc
ALL OTHER REFERRALS MUST BE BY GP ONLY
PTO TO COMPLETE AND SUBMIT THE FORM IF RELEVANT

Chairman: Steve Fogg

Chief Executive: Kevin McGee

RESEARCH MATTERS AND SAVES LIVES - TODAY'S RESEARCH IS TOMORROW'S CARE
Blackpool Teaching Hospitals is a Centre of Clinical and Research Excellence providing quality up to date care. We are actively involved in undertaking research to improve treatment of our patients. A member of the healthcare team may discuss current clinical trials with you.



If the patient has a partner:

- 1. Is the partner aware of the referral? Yes No
- 2. Is the partner willing to attend with the patient? Yes No

Is this patient a veteran? Yes No

Reason for Referral

.....
.....

Recent investigations/ **BLOOD TESTS** relevant to referral – **please give details and attach results:**

.....

Previous treatment for this problem - please give details and outcome:

.....

Medical/Surgical history.....

.....

Does the patient have any disability/illness which may impact on their sexual function?

.....

Medication:

.....

For Gender Identity Referrals: Gender assigned at birth:

Preferred name and Salutation to be used on envelopes:

Information which needs to be flagged e.g RISK/CONTACT RESTRICTIONS etc.

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IF EMAIL IS YOUR CHOSEN METHOD FOR CORRESPONDENCE-**THIS FORM MUST BE EMAILED IN IN THE FIRST INSTANCE.** SENSITIVE CORRESPONDENCE WILL BE PASSWORD PROTECTED.

IS EMAIL YOUR PREFERED CHOICE OF CORRESPONDENCE? YES / NO (Please delete)