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| --- | --- | --- | --- | --- |
| **Patient’s full name:** |  | | **DOB:** |  |
| **Address:** |  | | **NHS No:** |  |
| **Home Tel:** |  |
| **Mobile Tel:** |  |
| **Correspondence address if different:** |  | | **Email address:** |  |
| **Is the patient aware of the referral?** | |  | | |
| **Does the patient consent to be contacted by telephone/text?** | |  | | |
| ***If NO, please inform of preferred method of contact (eg. email/letter):*** | |  | | |
| **Permitted correspondence to home address?** | |  | | |

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| --- | --- | --- | --- |
| **Main Spoken Language:** |  | **Sexual Orientation:** |  |
| **Interpreter required?** |  | **Gender Identity:** |  |
| **Ethnicity:** |  | **Gender assigned at birth** |  |
| **Country of Birth:** |  | **Personal Pronouns:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details:** | | **GP Details if different to Referrer:** | |
| **Name:** |  | **Name:** |  |
| **Designation:** |  | **Address:** |  |
| **Base:** |  |
| **Email:** |  | **Telephone:** |  |
| **Telephone:** |  | **Date of Referral:** |  |

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| --- |
| **Why is this patient being referred?** |

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| **Are there any safeguarding concerns?** |  |
| **Any history of rape sexual assault or abuse?** |  |
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| **Any other further information Calderdale Sexual Health may need?** |