Priority Access Referral to Central Sexual Health

Patient Name:	
Date of Birth: CHI:	
Address:	
Post Code:	
Contact Tel No:	

GP / PN Name:	
Practice Details:	
Tel No:	

Medication	
Allergies	
Reason for referral e.g contraception type, sexual health screen	

***please tick (√) appropriate box**

Ever sexually active	Yes	☐	No	☐
Currently sexually active	Yes	☐	No	☐
Learning disability	Yes	☐	No	☐
Person understanding of information	Yes	☐	No	☐
Other agencies involved (Eg social services, CAMH) Specify:	Yes	☐	No	☐

Use of alcohol	Yes	☐	No	☐
Use of drugs	Yes	☐	No	☐
Self harm	Yes	☐	No	☐

Referred by	
Date	
Contact number	

Date	Any other relevant information

Email to: FV-UHB.sexualhealth@nhs.net