|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient’s full name:** |  | | **DOB:** |  |
| **Address:** |  | | **NHS No:** |  |
| **Address for correspondence if different from above:** |  | | **Home Tel:** |  |
| **Mobile Tel:** |  |
| **Email Address:** |  |
| **Is the patient aware of the referral?** | |  | | |
| **Does the patient consent to being contacted via telephone/text? (Please ensure number is correct)** | |  | | |
| ***If No, please inform of preferred method of contact (e.g. email/letter):*** | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Main Spoken Language:** |  | **Interpreter Needed?** |  |
| **Ethnicity:** |  | **Sexual Orientation:** |  |
| **Country of Birth:** |  | **Gender Identity:** |  |
| **Religion/Belief:** |  | **Personal Pronouns:** |  |

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

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

|  |  |
| --- | --- |
| **Are there any safeguarding concerns?** |  |
| **Any history of rape sexual assault or abuse?** |  |
| *Record details below* | |

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| **Any other further information Leeds Sexual Health may need?** |