**Long Acting Reversible Contraceptive (LARC) Referral Letter into Unity Sexual Health (WISH CLINIC)**

Primary Care North Somerset Practices

**PLEASE COMPLETE ALL SECTIONS TO ENSURE THE REFERRAL IS NOT REJECTED**

|  |  |
| --- | --- |
| **Patient Details** | **Referrer Details** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact no.(mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact no. (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact** Phone [ ] Yes / [ ] No  **Permissions** Text [ ] Yes / [ ] No  Leave message [ ] Yes / [ ] No | Referral Date (DD/MM/YYYY): \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_\_  Referrer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Please note that due to funding issues we are unable to insert IUS for gynaecological reasons alone e.g. postmenopausal endometrial protection or heavy menstrual bleeding in a patient who has been sterilised - these patients require a gynaecology referral.***

**Please highlight any information in the box below which may help with booking of appointment e.g. learning difficulties/complex medical history/ vulnerable patient/ requires language line or interpreter**

**Reason for referral – put an “X” in all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Copper intrauterine  device (IUD) insertion  (no hormones) | Levonorgestrel  intrauterine system  (IUS) insertion  (contains hormones) | IUD / IUS removal | IUD / IUS removal lost lost threads |
| Implant insertion | Implant removal (see below) | Deep Implant removal  (see below) |  |

Additional information (including detail of failed insertion/ removal if applicable) :

* **All lost thread referrals for removal MUST have an ultrasound report included from the last 6 months confirming that the IUS/IUD is in situ.**
* **For implant removals please state whether the implant was palpable.**

What date does/ did current contraception method expire? DD/MM/YY \_\_\_\_/\_\_\_\_/\_\_\_\_ (if applicable)

The patient’s current contraception or bridging contraception method provided today is:

**Please put an “X” in all that apply:**

|  |  |  |
| --- | --- | --- |
| Depo injection | Combined oral  Contraceptive pill | Progestogen only  Pill |
| Condoms | Nil |  |

Which of the following LARC criteria does this referral fulfil? **Please put an “X” in all that apply:**

|  |  |
| --- | --- |
| A) We are not signed up to a Local Authority contract with Public Health to deliver the above LARC method |  |
| B) We are contracted to deliver the above LARC method, but there are no professionals currently available trained in this method and my local authority commissioner has been informed |  |
| C) We are contracted to deliver the above LARC method, but patient prefers to be seen at WISH due to a previous difficult fit |  |
| D) Failed removal or insertion |  |
| E) Medical concerns |  |

Please inform the patient that due to increasing demand, there is often a wait of several weeks for complex insertions and/or removals.

**Medical History and Medication list**: Detail below or include full printout summary of patient record

Medical History and Medication List:

Learning Difficulties Yes No

Requires Translator Yes No

Other Vulnerabilities Yes No

Please give details:

**Please complete this form as fully as possible. Patients will be contacted by the WISH Team to arrange an appointment once the referral has been received and triaged.**

**Please email this form to the WISHclinic : wishclinic@nhs.net PLEASE DO NOT POST**

**N.B. It is UHBW Trust policy that if a patient cancels or refuses an appointment on two occasions, they will be returned to the care of their GP.**