

**ADULT REFERRAL FORM**

**Please complete and return to our secure e-mail** [lcp.SHOPT@locala.org.uk](mailto:SHOPT@locala.org.uk)

Targeted support for anyone over the age of 18, considered to be vulnerable and at risk of poor sexual health. All referrals will be received by the **Sexual Health Outreach and Prevention Team**. If you have any queries please contact us on **0333 043 6219**

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| --- | --- |
| **REFERRING AGENCY** | **REFERRER’S NAME & ROLE** |
| Click here to enter text. | Click here to enter text. |
| **CONTACT NUMBER** | **E-MAIL ADDRESS** |
| Click here to enter text. | Click here to enter text. |

**DATE OF REFERRAL** Click here to enter a date.

**HAS THE PERSON BEEN MADE AWARE OF THIS REFERRAL? Yes  No**

|  |  |
| --- | --- |
| **PERSON’S FULL NAME** | Click here to enter text. |
| **DATE OF BIRTH** | Click here to enter text. |
| **CURRENT ADDRESS** | Click here to enter text. |
| **CONTACT NUMBER** | Click here to enter text. |
| **NHS number (if known)** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **DISABILITY** | **PREFERRED GENDER** | **SEXUALITY** | **RELIGION** |
| Choose an item. | Choose an item. | Choose an item. | Click here to enter text. |
| **ETHNICITY** | | | |
| Choose an item. | | | |

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| **COMMUNICATION NEEDS** *(Please tick relevant options)* | |
| **INTERPRETER REQUIRED** *(please specify language)* | Click or tap here to enter text. |
| **EASY READ/ LARGE TEXT** | Click or tap here to enter text. |
| **BRAILLLE** | Click or tap here to enter text. |

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| **OTHER PROFESSIONAL INVOLVEMENT** | |
| Is this person engaging with any other support services?  If yes, please give details | No  Yes  Click here to enter text. |

**REFERRAL CRITERIA**

**Anyone referred into this Service needs to meet one or more of the following criteria:**

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| --- | --- | --- | --- | --- |
|  | |  | ***If yes, please give details…*** | |
| Affected by domestic abuse? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  | ***If yes, please give details…*** | |
| Affected by substance misuse? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  | ***If yes, please give details…*** | |
| Involved with the Criminal Justice Service? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  |  | |
|  | |  | ***If yes, please give details…*** | |
| Experienced sexual assault? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  | ***If yes, please give details…*** | |
| Current/ Past involvement in sex work? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  | ***If yes, please give details…*** | |
| Mental health support needs? | | Yes | Click here to enter text. | |
|  | | No |  | |
|  | |  | ***If yes, please give details…*** | |
| Affected by sexual exploitation/ trafficking? | | Yes | Click here to enter text. | |
|  | | No |  | |
| **PREVIOUS SEXUAL HEALTH INFORMATION** | | | |
| **Date of last smear test** | Click or tap to enter a date. | | |
| **Date of last STI screen** | Click or tap to enter a date. | | |
| **Contraception method** | Click or tap here to enter text. | | |

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| **HOW CAN WE HELP?**  What support does the young person need from our service?  ***Please give details of any sexual health risks i.e. unplanned pregnancy or risk of sexually transmitted infections, any barriers preventing access to services, and any interventions completed to date*** |
| Click here to enter text. |

**\*\*\*Please confirm the client has consented to this referral and the sharing of their information with other agencies during the risk assessment process\*\*\***

**YES  NO**

**DOES THIS CLIENT POSE A RISK TO THE WORKER? Yes  No**

**If YES please give details:**

Click here to enter text.

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