

**ADULT REFERRAL FORM**

**Please complete and return to our secure e-mail** lcp.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)** |  |

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| --- | --- | --- | --- |
| **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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