

**Referral Form**

**Please complete and return to Sexual Health Outreach & Prevention Team on** **lcp.SHOPT@locala.org.uk**

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

**DATE OF REFERRAL** Click or tap to enter a date.

**HAS THE SERVICE USER BEEN MADE AWARE OF THIS REFERRAL? Yes** [ ]  **No** [ ]

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| Please complete the details for the person you are referring in |
| **FULL NAME** | Click or tap here to enter text. |
| **DATE OF BIRTH** | Click or tap to enter a date. |
| **CURRENT ADDRESS** | Click or tap here to enter text. |
| **CONTACT NUMBER** | Click or tap here to enter text. |

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| **PARTNER’S FULL NAME** | Click or tap here to enter text. |
| **DATE OF BIRTH** | Click or tap to enter a date. |
| **CURRENT ADDRESS (if different)** | Click or tap here to enter text. |

**PREGNANCY TEST CONFIRMED? Yes** [ ]  **No** [ ]

**Estimated Due Date** Click or tap to enter a date.

Please enter details of all children below

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| **CHILD 1** |
| **Name:**Click or tap here to enter text. | **DOB:**Click or tap to enter a date. | **CIN** [ ]  **CP** [ ]  |
| **CHILD 2** |
| **Name:**Click or tap here to enter text. | **DOB:**Click or tap to enter a date. |  **CIN** [ ]  **CP** [ ]  |
| **CHILD 3** |
| **Name:**Click or tap here to enter text. | **DOB:**Click or tap to enter a date. | **CIN** [ ]  **CP** [ ]  |

**REFERRAL CRITERIA**

**Women being referred into SWANS need to meet at least one of the following criteria.**

Domestic Abuse YES [ ]  NO [ ]

Date discussed at MARAC/ DRAMM Click or tap to enter a date.

Substance use/ poly-drug use YES [ ]  NO [ ]

Alcohol use YES [ ]  NO [ ]

Involved with Criminal Justice System YES [ ]  NO [ ]

Mental Health issues YES [ ]  NO [ ]

Please state diagnosis ……. Click or tap here to enter text.



Involvement in sex work/ sex industry YES [ ]  NO [ ]

Victim of Modern Slavery/ Human Trafficking YES [ ]  NO [ ]

Previous children removed? YES [ ]  NO [ ]

**WHAT SUPPORT IS REQUIRED FROM SWANS?**

Would the Patient benefit from one-to-one support from an Engagement Worker?

\* ***Consent must be gained for us to be able to make contact to offer support.***

YES [ ]  NO [ ]

If yes, What support is required?

Click or tap here to enter text.

Patient would like to access the SWANS clinic?

YES [ ]  NO [ ]

Discussion at MDT Risk Assessment only?

*\* Discussed at monthly SWANS meeting to assess risk/ safeguard Patient and unborn*

YES [ ]  NO [ ]

Post-natal contraception offer?

YES [ ]  NO [ ]

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| **PLEASE PROVIDE INFORMATION IN SUPPORT OF THE REASON FOR THIS REFERRAL*****Please add as much information as possible to support this referral*** |
| Click or tap here to enter text. |

**ARE THERE ANY KNOWN RISKS TO PROFESSIONALS? Yes** [ ]  **No** [ ]

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| Please specify all agencies and reasons they are involved in supporting the above service user and provide their contact details: |
| Agency: Click or tap here to enter text.  | Contact details:Click or tap here to enter text.  | Reasons for support:Click or tap here to enter text. |
| Agency:Click or tap here to enter text. | Contact Details:Click or tap here to enter text. | Reasons for Support:Click or tap here to enter text. |
| Agency:Click or tap here to enter text. | Contact Details:Click or tap here to enter text. | Reasons for Support:Click or tap here to enter text. |

**Please complete and return to our secure e-mail** **lcp.SHOPT@locala.org.uk**

It is good practice to seek **permission** from the service user when making a referral **HOWEVER DO NOT** inform the service user if you have any reason to believe this would put the service user or their baby at risk.