

**Referral Form**

**Please complete and return to Sexual Health Outreach & Prevention Team on** [**lcp.SHOPT@locala.org.uk**](mailto:SHOPT@locala.org.uk)

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

|  |  |
| --- | --- |
| 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. |

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

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

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

|  |  |  |
| --- | --- | --- |
| 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**](mailto: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.