

Date: _ / _ / _

Barts and The London sexual health referral form

Please send this form (preferably by fax) to: Ambrose King Centre,
Tel: 020 7377 7311 Fax: 020 7377 7648 or Barts Sexual Health Centre,
Tel: 020 7601 8090 Fax: 020 7601 8601

AND give this form to the patient to take to either sexual health clinic.

Client details:			
Name:	Sex:	M: <input type="checkbox"/>	F: <input type="checkbox"/>
Address:	DOB:		
	Tel:		
	Mobile:		
	Interpreter required	Y <input type="checkbox"/>	N <input type="checkbox"/> Language:
Client has consented to be contacted by:			
Letter <input type="checkbox"/>	Telephone <input type="checkbox"/>	Mobile <input type="checkbox"/>	Text <input type="checkbox"/>
Reason for referral:			
STI screen <input type="checkbox"/>	Treatment <input type="checkbox"/>	Partner notification <input type="checkbox"/>	Other <input type="checkbox"/>
Client History:			
Abnormal Discharge: <input type="checkbox"/>	Genital Ulcer: <input type="checkbox"/>	Dysuria: <input type="checkbox"/>	Warts: <input type="checkbox"/>
Other <input type="checkbox"/>	Details:		
Recurrent conditions <input type="checkbox"/>	Details:		
Additional History:			
Tests and results: (With date)			
Gonorrhoea <input type="checkbox"/>	Positive / Negative	Chlamydia <input type="checkbox"/>	Positive / Negative
Syphilis <input type="checkbox"/>	Positive / Negative	Herpes <input type="checkbox"/>	Positive / Negative
HIV <input type="checkbox"/>	Positive / Negative	Other:	
Treatment Given:			
Referred by:			
Name:	Designation:		
Address:	Tel:		
	Date:		
For health professional to complete:			
Date referral received: _ / _ / _	Appointment given:	Date: _ / _ / _	Time: _ : _
			Attended: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action notes:			