

**Sexual Health Referral Form**

This form is for professionals to refer young people aged 13-19 into our young people’s service. Please complete all fields and return this form via secure email to vcl.orbishyp@nhs.net.

**If you do not have an nhs.net or gov.uk email address, you MUST enter [SECURE] in the subject header of the email.**

If you would like to speak to a member of the team regarding your referral, please contact 01706 202 444. If we are unavailable to take your call, please leave a voicemail and we will get back to you.

Patient details

|  |  |  |  |
| --- | --- | --- | --- |
| First name |  | Last name |  |
| Gender |  | DOB  |  |
| Country of birth  |  | Ethnicity |  |
| Address  |  | School name/address |  |
| Young person’s contact number |  |  |
| Emergency contact name |  | Relationship to the young person |  |
| Emergency contact number  |  | Is the emergency contact aware of the referral |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do we have permission to contact the emergency contact? | Yes |  | No |  | Only in an emergency  |  |
| Do we have permission to write to the young person’s home address? | Yes |  | No |  | Only in an emergency |  |
| Do we have permission to contact the young person via the contact telephone number? | Yes |  | No |  | Only in an emergency |  |



Involvement from social care

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the young person known to social care? | Yes |  | No |  |
| Is there an open case with social services? | Yes |  | No |  |

|  |  |
| --- | --- |
| If yes, please provide more information |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Does the young person have a social worker?  | Yes |  | No |  |  |

|  |  |
| --- | --- |
| Name of the designated social worker |  |
| Contact Number (if known) |  |



Involvement from other agencies

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the young person involved with any other agencies? | Yes |  | No |  |

|  |  |
| --- | --- |
| If yes, please provide more information |  |



Vulnerabilities

Does the young person have any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug and alcohol issues | Yes |  | No |  |
| Mental health issues | Yes |  | No |  |
| Learning difficulties or disabilities | Yes |  | No |  |
| Looked after child | Yes |  | No |  |
| Refugee/Asylum seeker/ Unaccompanied child/ Newly arrived in the UK | Yes |  | No |  |



Referral information

What is the reason for the referral?

|  |  |
| --- | --- |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the young person have a long-term disability? |  | Yes |  | No |
| Does the young person have a current problem or any symptoms? |  | Yes |  | No |
| Has the young person used or use substances (regularly or recreationally)?  |  | Yes |  | No |
| If so, please specify |  |
| Does the young person consent to a referral into Early Break for support around substance use? |  | Yes |  | No |



Referrer information

|  |  |  |  |
| --- | --- | --- | --- |
| Contact name |  | Organisation |  |
| Email address |  | Telephone number |  |
| Date of referral |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you discussed your concerns with the young person? | Yes |  | No |  |
| Have you discussed the referral with the young person? | Yes |  | No |  |
| Has the young person consented to the referral? | Yes |  | No |  |



What’s next?

Please return completed referral forms to*:* vcl.orbishyp@nhs.net

* Referrals will be assessed and responded to within 7 days.

