|  |  |
| --- | --- |
| Name: |  |
| Address |  |
| Phone Number |  |
| Date of Birth |  |
| GP name  |  |
| Practice Address |  |
| Practice email address  |  |
| Relevant medical history  |  |
| Relevant gynaecological history Please send any recent USS or investigations for HMB with this form. |  |
| Obstetric history  |  |
| Date referred  |  |
| Name and position of referrer |  |
| **Completion by SHS following IUS fit**  |  |
| Date of fit |  |
| Device fitted  |  |
| Any issues/concerns |  |
| Fitted by  |  |
| Date of response to GP  |  |