Complex Long-Acting Reversible Contraceptive (LARC) Referral Letter into HCRG Care Group Integrated Sexual Health Service.

PLEASE CHECK IF YOU HAVE A BOROUGH WIDE SERVICE WHICH IS ABLE TO SUPPORT PRIOR TO REFERRAL AND COMPLETE ALL SECTIONS TO ENSURE THE REFERRAL IS NOT REJECTED

**Is the patient aware of this referral to HCRG for complex LARC? YES/NO**

|  |  |
| --- | --- |
| **Patient Details** | **Referrer/GP Details** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact** Phone [ ] Yes / [ ] No  **Permissions**  Leave message [ ] Yes / [ ] No | Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Please note that due to funding we are unable to insert IUS for gynaecological reasons alone e.g. postmenopausal endometrial protection or heavy menstrual bleeding or in a patient who has been sterilised - these patients require a gynaecology referral.***

**Please highlight any information in the box below which may help with booking of appointment e.g. learning difficulties/complex medical history/ vulnerable patient/ requires language line or interpreter**

**Reason for referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Difficult IUD/IUS fitting for  contraception. | Suspected malposition of IUS/IUD being used for contraception, including non-visible threads for assessment or removal | Complex contraception problems (e.g. coexistent medical conditions) | Deep, broken or bent sub-dermal implants for removal or assessment |
|  |  |  |  |
|  |  |  |  |

Additional information (including detail of failed insertion/ removal if applicable):

* **All lost thread referrals for removal MUST have an ultrasound report included from the last 6 months confirming that the IUS/IUD is in situ.**
* **For implant removals please state whether the implant was palpable.**

What date does/ did current contraception method expire? DD/MM/YY \_\_\_\_/\_\_\_\_/\_\_\_\_ (if applicable)

The patient’s current contraception or bridging contraception method provided today is:

**Please put an “X” in all that apply:**

|  |  |  |
| --- | --- | --- |
| Depo injection | Combined oral  Contraceptive pill | Progestogen only  Pill |
| Condoms | Nil |  |

Please inform the patient that due to increasing demand, there is often a wait of several weeks for complex insertions and/or removals.

Clinicians to discuss the following and tick appropriate box during consultation:

* Inform the patient that although best effort will be given to remove it at this appointment, it may not be possible.
* Inform the patient that if they are more than 10 minutes late for their appointment it may have to be rescheduled.
* Advise the patient not to bring children to this procedure appointment.
* Request an interpreter for the patient, if needed.

**Medical History and Medication list**: Detail below or include full printout summary of patient record

Learning Difficulties Yes No

Requires Interpreter Yes No

Other Vulnerabilities Yes No

Any other

communication needs Yes No

Please give details:

Medical History and Medication List:

**Please complete this form as fully as possible. Patients will be contacted by the HCRG Care Group Team to arrange an appointment once the referral has been received and triaged.**

**Please email this form to the relevant borough service PLEASE DO NOT POST**

**Email subject header Complex LARC referral**

**Cheshire West & Chester Complex Referral**

* [**cwac.shreferrals@hcrgcaregroup.com**](mailto:cwac.shreferrals@hcrgcaregroup.com)
* **N.B. It is policy that if a patient does not attend, cancels or refuses an appointment on two occasions, they will be returned to the care of their GP.**