**Cheshire West & Chester Primary Care**

**Urgent Referral Form**

This form is for completion by Cheshire West & Chester Primary Care colleagues to refer patients from their practice who have positive tests results for gonorrhoea / syphilis or HIV, or who require an IUD (copper coil) for emergency contraception, into the specialist sexual health service. This form should be completed by a registered professional.

We aim to contact your patients within 48 hours of a referral (or the next working day is this is a bank holiday or weekend) appropriate to the reason for referral.

Please inform the patient that we will contact them by phone and to be aware the call will be from an unknown number. By agreeing to the referral, patients agree that we can contact them by phone (call or text) *or email / post as a last resort.*

To refer:

* Fill in the referrer details
* Confirm that the patient has consented to be contacted by the specialist sexual health clinic
* Complete the patient demographic details, including reason for referral \*
* Email to [cwac.shreferrals@hcrgcaregroup.com](mailto:cwac.shreferrals@hcrgcaregroup.com)
* ***This referral process is for urgent referrals only; patients referred for any other reasons will not be contacted or booked an appointment***

For all other service information, please visit:

<https://www.thesexualhealthhub.co.uk/services-near-you/cheshire-west-and-chester/>

**Referrers details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Professionals Name |  | | |
| Address / Practice |  | | |
| Date of referral |  | I confirm that the patient has consented to be contacted by the sexual health service (X) |  |

**About the patient:**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth |  |
| Address |  |
| Contact Telephone Number |  |
| Email address |  |

**Reason for Referral (X where appropriate):**

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency IUD |  | Positive Gonorrhoea Test |  |
| Positive initial HIV Test |  | Positive Syphilis Test |  |

Please provide any further relevant details (date/details of STI test/result/symptoms/medications/ accessibility needs.