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