Once completed please email to: **sexualhealth.teesside@nhs.net**

Subject title: **Vasectomy Referral**

|  |
| --- |
| **Patient Demographics** |
| Name: |  |
| Address |  |
| Phone Number |  |
| Date of Birth |  |
| **GP Practice Details** |
| GP name  |  |
| Practice Address |  |
| Practice email address  |  |
| Relevant medical history  |  |
| Relevant urology history  |  |
| Name and position of referrer |  |
| **Referrers Details** |
| Referral date |  |
| Name of referrer |  |
| Position of referrer |  |

Please see next page for **exclusion criteria**

|  |
| --- |
| **Exclusion criteria** |
| * Anybody under the age of 18
* Lack of consent / Lack of capacity to give informed consent
* Genital infections – Balanitis, Epididymitis, Orchitis or active sexually transmitted disease
* Scrotal skin infection/ inflammation
* Structural abnormalities – Varicocele, Hydrocele, Cryptorchidism, Inguinal hernia, retractile/ ascending testes, small tight scrotum
* Previous scrotal surgery – undescended testes, excision of varicocele/hydrocoele/ inguinal hernia
* Obesity (BMI more than 35)
* Scrotal skin hypersensitivity/ brisk cremasteric reflex
* Bleeding disorders
* Taking blood thinners such as warfarin (If takin aspirin patient needs to stop it 3 days prior and re-start 2 days after the procedure)
* Allergy to local anaesthetics
* Tendency to faint
* Service user refusal of local anaesthetic
* Those deemed unsuitable for local anaesthetic
	+ Drug or alcohol misuse
	+ Diabetes (Last HbA1C must be less than 58)
	+ Unstable heart conditions
* Anxiety affecting the ability to lie still for 30 minutes
 |