**Medway Sexual Health Services Outreach Referral form**

We are able to provide one to one or group support to those with additional sexual health needs. Please complete the referral form below and return to [kchft.medwaysexualhealth@nhs.net](mailto:kchft.medwaysexualhealth@nhs.net) via secure email.

|  |  |
| --- | --- |
| **Referring Agency’s details** | |
| Referring agency: |  |
| Name and position of referrer: |  |
| Contact address: | |
| Phone number: |  |
| Email Address: |  |
| **Client details** |  |
| Name: |  |
| Date of birth: |  |
| Ethnicity: |  |
| Contact address: | |
| Phone number: |  |
| **Social care involvement** | |
| Yes/ No |  |
| Multi-agency involvement |  |
| Organisation and practitioner | Contact details: |
| Reason for referral – Please give as much detail as possible | |
| Parents/carers aware, if appropriate? Yes/No | |
| Contact details of parents/carer: | |
| Signatures | |
| I confirm that the information above is accurate and I consent to my information being shared as above.  Yes/No | |
| Signed (young person): |  |
| Print name: |  |
| Date: |  |
|  |  |
| Signed (referrer) |  |
| Print name: |  |
| Date: |  |

**Please email to:** [**kchft.medwaysexualhealth@nhs.net**](mailto:kchft.medwaysexualhealth@nhs.net)

**For any queries phone 0300 123 1678 (8am-8pm Monday to Friday and 9am-1pm on Saturdays)**

**For office use only:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date received: |  | | | | |
| Copy provided to (please tick) | Sexual Health Nurse | METRO | Open Road | Turning Point | HACO |
| Who the referral has been allocated to and date |  |  |  |  |  |