Appendix 4 Contraception referral

**Contraception Referral Form**

**Please send referral form to:**

Chris Loader (Health Advisor)

Contraception and Sexual Health Department

Salisbury NHS Foundation Trust

Salisbury District Hospital

Salisbury

Wiltshire

SP2 8BJ

Telephone: 01722 425120

Email: chris.loader@salisbury.nhs.uk

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Date of Birth |  |
| Telephone number: HomeContact by phone ok? Yes⁭ No⁭ Mobile  |  |
| GP Name and AddressOk to inform GP? Yes / No |  |
| Reason for referral e.g. teenager, drug/ alcohol misuse, health morbidity |  |
| Other agencies involvede.g. social services, ADAS |  |
| Gestation at referral | /40 |
| EDD |  |
| Previous Pregnancies | Gravida Para Misc TOP |
| Was this a planned pregnancy? |  Yes ⁭ No ⁭ |
| Previous contraception |  |
| Client happy to be contacted in pregnancy to discuss contraception options |  Yes ⁭ No ⁭If no, would prefer PN contact only  |
| Any other concerns, including significant medical history |  |
| Referred by Job titleContact details |  |

Copy to: ⁭Pregnancy notes ⁭Health Adviser ⁭GP ⁭Hospital notes