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**Psychosexual referrals into SWISH**

**PLEASE COMPLETE ALL SECTIONS. *Please e-mail your referral form to SwishPSM@somersetft.nhs.uk***

***Please note that due to funding issues we are only able to accept referrals from NHS providers in Somerset.***

***We are commissioned to provide brief interpretative interventions for patients with psychosexual problems, we are not commissioned to investigate or provide medication. We are not able to provide long term support.***

***Please see our website for details of problems that are likely to respond to psychosexual counselling, and problems for which we cannot provide counselling.***

**Section A:**

|  |  |
| --- | --- |
| **Patient Details** | **Referrer Details** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact no.(mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact no. (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact** Phone [ ] Yes / [ ] No**Permissions**  Text [ ] Yes / [ ] No Leave message [ ] Yes / [ ] No  | Referral Date (DD/MM/YYYY): \_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_\_Referrer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Practice Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Practice address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section B:**

Please indicate your reason for referral:

 Vaginismus, loss of libido, difficulties with orgasm 

 Non-consummation and dyspareunia 

 Erectile dysfunction, ejaculatory problems 

 Emotional and psychosexual sequelae of sexually transmitted infections 

 Difficulties following childbirth 

 Emotional and psychosexual effects of medical and surgical interventions, including miscarriage and

 TOP 

 Psychosexual sequelae of sexual abuse 

 Sexuality, cancer and terminal care 

 Effects of ageing, disability or illness on sexuality 

 Psychosexual problems related to infertility and ending of fertility 

**Section C:**

Please describe the Psychosexual problem (including relevant investigations and results):

Please add any details you feel will help your patient:

**Section D:**

Medical history:

Medication:

Allergies:

Physical:

Mental Health:

Relevant safeguarding issues:

Language barriers:

Other vulnerabilities:

Please feel free to attach a print out of past medical history or relevant consultation if appropriate