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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.***

***25793***

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GP Practice or hospital name and speciality Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GP Practice/hospital address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section B:**

Please indicate the sexual problem:

Vaginismus, 

Dyspareunia 

Loss of libido, 

Difficulties with orgasm 

Non-consummation 

Erectile dysfunction

Ejaculatory problems 

**Section C:**

Please describe the Psychosexual problem;

Please provide 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 printout of past medical history or relevant consultation if appropriate