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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