**SWISH**

Referral into SWISH Targeted outreach team

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**REFERRAL PATHWAY IN TO SWISH other professional services or organisations**

Professional aware of vulnerabilities and a need for contraception and or sexual health in their client or group

Referral for SWISH is made by completing a referral form on the professional page of [www.swishservies.co.uk](http://www.swishservies.co.uk) for the targeted outreach team

Or by completing a SWISH referral form and emailing it to: [swishtoteam@SomersetFT.nhs.uk](mailto:swishtoteam@SomersetFT.nhs.uk)

On receipt of a referral, The TOT member adds patient to excel spread sheet and check if they have been to SWISH before and add to Idox Lilie

Targeted outreach team nurse/s contacts patient/professional and offer or carry out an initial phone consultation

Contact will be attempted within 48 hours (9-5 Monday to Friday) or next working day if received on a Friday PM

3 attempts are made to contact the patient by preferred method, over 3 days and then if no contact professional will be contacted

If unable to contact patient by phone and agreed a letter may be sent

If patient does not attend or cancels the appointment should be rebooked and the professional involved in making the appointment will be informed

Following a phone consultation, a face-to-face appointment if needed will be made at a location within Somerset nearest to them and follow up if needed arranged

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| **Referral into SWISH Targeted outreach team**  **All completed forms to be emailed to** [**swishtoteam@somersetft.nhs.uk**](mailto:swishtoteam@somersetft.nhs.uk)  **By completing and signing this form you have agreed to this referral and to information being shared between SWISH and other professional organisation/service**  **Signed………………………………… Name……………………………. Date……………….**  **Circle preferred location of face-to-face consultation**  Taunton, Bridgwater, South Petherton, Yeovil, Minehead, Frome, Wells | |
| Surname: | First name: |
| Date of Birth: | Age: |
| Address  Can send a letter **Y N** | Postcode |
| Mobile Number: | Email address: |
| Ok to Text **Y N** | Ok to Call **Y N** |
| Professionals name: | Professionals contact details: |
| GP Name if Known: | GP Surgery: |
| Happy for us to contact your GP- **Y N** | |
| Reason for referral to Targeted outreach team: | |
| If female current method of contraception: **Y N** | If **Y** Method of contraception? |
| **Method of contraception requested:**  Depo Hormonal Coil Non-Hormonal Coil Implant Unsure | |
| Known to (Circle) SDAS SIDAS SARC MHT Other………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….  Social circumstances…………………………………………………………………………….  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………  Previous contraception………………………………………………………………………….  Parity………**Gravidity**…………...  Any other significant history? …………………………………………………………….  ………………………………………………………………………………………………………  ………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………………………………………………………………………… | |
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| Referred by: | Contact No : |

