Urgent Referral Form

We aim to contact the patient within 48 hours of a referral (or the next working day if this is a bank holiday or weekend day) appropriate to the referral reason.

Please inform the patient that we will contact them by phone within 48 hours and to be aware the call will be from an unknown number. *By agreeing to the referral, patients are in agreement that we can contact them by phone (call or text) or email and post as a last resort.*

To refer:

- Fill in the referrer details
- Confirm that the patient has consented to be contacted by the sexual health clinic
- Fill in the patient demographic details
- Please tick the reason for referral*
- Email to mft.emergencyreferrals@nhs.net

This email address is for urgent referrals only and is checked a minimum of three times per day.

***Note: Patients referred for any other reason(s) will not be contacted or booked an appointment.**

For all other service information please visit www.thenorthernsexualhealth.co.uk.

Referrer details

Professional's name:		
Professional's address/surgery:		
I confirm that the patient has consented to be contacted by the sexual health service (please ✓)		

About the patient

Name:	
Date of birth:	
Primary telephone number:	
Address: (so we can direct the patient to the most appropriate clinic)	
Email address:	

Reason for referral (tick ✓ as appropriate)

Emergency IUD		Positive initial HIV test	
Urgent IUD/ IUS or Implant problems		Positive gonorrhoea test	
Deep Implant		Positive syphilis test	