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| **Section 1:** |
| **(\*) Patients must be informed of their positive HIV result BEFORE referral.****YOU DO NOT NEED TO PERFORM CONFIRMATORY HIV TESTING PRIOR TO REFERRAL.** **This will be done at their first appointment in clinic.****Please follow this** [**link**](https://www.tht.org.uk/hiv-and-sexual-health/being-diagnosed-hiv/newly-diagnosed) **for FAQ’s from newly diagnosed patients to assist you****Is the patient systemically unwell? YES NO****If YES** – Contact the relevant clinic directly. If unable to get through, or out of hours, contact the Hospital HIV Consultant on-call via relevant hospital switchboard for advice or call Consultant Connect (GSTT/KCH).Urgent queries for <18 Year Olds – please contact paediatric ID consultant oncall via GSTT switchboard 0207 188 7188**REFERRALS VIA EMAIL ONLY (not the ERS system). Please tick preferred clinic as appropriate** |
| **University Hospital Lewisham****The Alexis Clinic****SE13 6LH****Tel Reception:** 0203 192 6752**HIV SHO:** Bleep 7252 via UHL main switchboard **Email referral to:** **LH.AlexisClinic@nhs.net** | **Queen Elizabeth Hospital****Trafalgar Clinic, Woolwich****SE18 4QH****Tel Reception:** 0208 836 6969/5767/5768**Email referral to:** **lg.trafalgarpatientqeh@nhs.net****Website:** [www.lewishamandgreenwich.nhs.uk/sexual-health-services](http://www.lewishamandgreenwich.nhs.uk/sexual-health-services) |
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| **Guy’s and St Thomas’ Hospital****Harrison Wing, Guy’s Hospital** **SE1 9RT****Tel Reception:** 0207 188 2815**HIV Nurses:** 0207 188 2636 **Email referral to:** **gst-tr.HarrisonWing@nhs.net** |
| **Website:** <https://www.guysandstthomas.nhs.uk/our-services/hiv-harrison-wing>  |

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| **King’s College Hospital****The Caldecot Centre, Denmark Hill****SE5 9RS****Tel Reception:** 0203 299 5000**Email referral to:** **kch-tr.nursesatcc@nhs.net****Urgent advice:** kch-tr.sexualhealthconsultants@nhs.net **or****HIV SpR:** Bleep 515 via KCH switchboard**Website:**<https://www.kch.nhs.uk/services/services-a-to-z/hiv/> | **King’s College Hospital** **Beckenham Beacon, Bromley****BR3 3QL****Tel Reception:** 01689 866 622**HIV Nurses:** 01689 866 647**Email referral to:** **kch-tr.bb-medical-queries@nhs.net****Website:**<https://www.sexualhealthbromley.co.uk/clinics/hiv-clinic> |
| **King’s College Hospital Community Clinics****Tessa Jowell Health Centre, East Dulwich,** **SE22 8EY***Weekly doctor-led clinic every Thursday morning*  | **Hurley and Riverside Practice, Vauxhall,** **SW8 2JB***Monthly nurse-led clinic every Thursday afternoon* *3-monthly doctor-led clinic on Wednesday afternoons*  |
| **Paxton Green Health Centre, Gipsy Hill,** **SE21 8AU***Monthly doctor or nurse-led clinic on Wednesday afternoons* | **Clapham Family Practice, Clapham High Street,** **SW4 7DB***Monthly nurse-led clinic on Thursday mornings* *3-monthly doctor-led clinic on Wednesday afternoons*  |
| **Email referral to:** **kch-tr.nursesatcc@nhs.net***Depending on clinical status, initial appointments will usually be at the Caldecot Centre* |
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| **< 18 years old/Paediatrics** **Evelina London Children’s Hospital,** **Guy’s & St Thomas’ Hospital****SE1 7EH**Family Clinic**Tel:**0207 188 4679 (team PA) **Email referral to:** FAO Dr Julia Kenny**gst-tr.ELCHPaedIMMIDReferrals@nhs.net**   | **The Caldecot Centre,** **King’s College Hospital****SE5 9RS** Family and Young Person’s Clinic Tel: 07973456734**Email referral to:**  **kch-tr.caldecotypcns@nhs.net** |

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| **Section 2: Patient Details** |
| Title (Mr/Mrs) |  | NHS No. |  |
| First name  |  | Surname |  |
| DOB |  | Gender |  |
| Address |  |
| Telephone No. |   | Email |  |
| Spoken Language |  | Needs Interpreter? |  |

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| **Section 3a: Referral information – NEW POSITIVE HIV DIAGNOSIS**  |
| Date of positive HIV test |  |
| Reason for HIV test | Routine Sexual health Screen HIV Symptoms (please describe in comments section below) |
| Comments/further information |  |
| **Date patient informed of positive HIV result by GP (\*)** |  |
| Date of referral to HIV services |  |
| Is the patient aware of this referral?  | Yes No | Consent to contact via telephone? | Yes No |
| Is anyone else aware of their HIV diagnosis? (please give details)  |  |

**Please fill out EITHER Section 3a OR Section 3b:**

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| **Section 3b: Referral information – TRANSFER OF CARE FOR PERSON LIVING WITH HIV** |
| Date of HIV diagnosis  |  | Name & location of previous HIV clinic |  |
| On HIV treatment? | Yes No | Name of medication & number of tablets remaining |  |
| Comments/further information  |  |
| Is the patient aware of this referral? | Yes No | Consent to contact via telephone? | Yes No |
| Is anyone else aware of their diagnosis? (please give details) |  |

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| **Section 4: Referrer Details** |
| Name & Role |  |
| Practice Name |  |
| Address |  |
| Telephone |  |
| Email |  |
| **Signature**  |  | **Date of signature** |  |

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| **Section 5: Past Medical History** |
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| **Section 6: Medications** |
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| **Section 7: Vaccination History** |
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