

Referral Form for External SHIP Team referrals

Department of Sexual Health & HIV

King’s College Hospital

**Please fill out the form below and sent to: kch-tr.sexualhealthship@nhs.net**

**For telephone enquiries and advice call us on 020 3299 3759**

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| --- | --- | --- | --- |
| **Patient Name:** |  | **D.O.B** |  |
| **Address** **Including Postcode:**  |  |
| **Phone:** |  | **Email:****(if able)**  |  |
| **Does the patient consent to being contacted by:****Letter: YES / NO Phone: YES / NO Text Message: YES / NO Email: YES / NO** |
| **GP Details:****(if available)** |  |
| **GP Phone:****(if available)** |  | **Interpreter required? Language?** |
| **Chaperone:** Do you require a chaperone? **YES / NO** |
| **Please include reason for referral and any other relevant clinical details:** |
| **Name of referrer:** |  | **Organisation:** |  |
| **Contact details of referrer**  | Email: | **Role:**  |  |
| Telephone: |