

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**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: |