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**Psychosexual referrals into SWISH**

**PLEASE COMPLETE ALL SECTIONS. *Please e-mail your referral form to SwishPSM@somersetft.nhs.uk***

***Please note that due to funding issues we are only able to accept referrals from NHS providers in Somerset.***

***We are commissioned to provide brief interpretative interventions for patients with psychosexual problems, we are not commissioned to investigate or provide medication. We are not able to provide long term support.***

***Please see our website for details of problems that are likely to respond to psychosexual counselling, and problems for which we cannot provide counselling.***

**Section A:**

|  |  |
| --- | --- |
| **Patient Details** | **Referrer Details** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact no.(mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact no. (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact**  Phone [ ] Yes / [ ] No  **Permissions**  Text [ ] Yes / [ ] No    Leave message [ ] Yes / [ ] No | Referral Date (DD/MM/YYYY):  \_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_\_  Referrer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section B:**

Please indicate your reason for referral:

Vaginismus, loss of libido, difficulties with orgasm 

Non-consummation and dyspareunia 

Erectile dysfunction, ejaculatory problems 

Emotional and psychosexual sequelae of sexually transmitted infections 

Difficulties following childbirth 

Emotional and psychosexual effects of medical and surgical interventions, including miscarriage and

TOP 

Psychosexual sequelae of sexual abuse 

Sexuality, cancer and terminal care 

Effects of ageing, disability or illness on sexuality 

Psychosexual problems related to infertility and ending of fertility 

**Section C:**

Please describe the Psychosexual problem (including relevant investigations and results):

Please add any details you feel will help your patient:

**Section D:**

Medical history:

Medication:

Allergies:

Physical:

Mental Health:

Relevant safeguarding issues:

Language barriers:

Other vulnerabilities:

Please feel free to attach a print out of past medical history or relevant consultation if appropriate