**Sheffield Psychosexual Therapy Service Referral Form**

*The Fitzwilliam Centre*

*143-145 Fitzwilliam Street*

*Sheffield, S1 4JP
0114 271 6979*

**PLEASE NOTE:**

* Please ensure that the information you provide is up-to-date and correct. If the individual is screened as appropriate to be accepted onto the Sheffield Psychosexual Therapy Service pathway then is it their responsibility to inform us of any changes to their situation, this includes changes of address and contact details.
* **We no longer accept referrals for Erectile Dysfunction due to recent changes to the pathway and would advise that referrals are forwarded to the Royal Hallamshire Hospital Andrology Department.**
* This referral form must be completed electronically and then submitted to the following email address: psychosexualtherapyservice@shsc.nhs.uk
* More information about the service can be found on the following webpage: [www.shsc.nhs/services/sheffield-psychosexual-therapy-service](http://www.shsc.nhs/services/sheffield-psychosexual-therapy-service).

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| **Date of referral**  |  |
| **Patient’s name** |  |
| **Preferred Name and Pronouns** |  |
| **Date of birth** |  |
| **NHS Number**  |  |
| **Patient’s address** |  |
| **Preferred telephone number** |  |
| **Name of registered GP** |  |
| **GP contact details** | Address:Telephone:Email: |
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1. **Detailed reason for referral:**

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1. **Results of pre-referral screens (if undertaken)**

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1. **Mental health and other diagnosis**

Please tick to say whether the patient is or has suffered from the following:

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| Depression |[ ]  Anxiety / anxiety disorders |[ ]
| Psychosis (incl. Schizophrenia) |[ ]  Schizoaffective disorder  |[ ]
| Bipolar disorder |[ ]  Mania |[ ]
| Body dysmorphic disorder (BDD) |[ ]  Eating disorder |[ ]
| Personality disorder |[ ]  Obsessive compulsive disorder |[ ]
| Suicidal thoughts  |[ ]  Suicide attempts |[ ]
| Alcohol misuse |[ ]  Substance misuse |[ ]
| Other mental health diagnosis |[ ]  Any mental health agencies involved |[ ]

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| --- | --- |
| Learning difficulty/Intellectual disability |[ ]  Autism |[ ]
| Attention deficit hyperactivity disorder (ADHD) |[ ]  Other  |[ ]

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| Please provide additional information for any diagnosis that have been ticked. |

1. **Risk**

Please tick below to indicate a current and/or historical risk

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| --- | --- | --- |
| Risk of self-harm |[ ]  Risk to others |[ ]  Risk from others |[ ]
| Risk to children |[ ]  Risk of suicide |[ ]  Risk of self-neglect |[ ]
| Forensic/Prison history |[ ]  Any safeguarding concerns |[ ]  Other |[ ]

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| Please provide additional information for any risks that have been ticked.  |

1. **Physical Health**

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| **Any current physical health diagnoses?** |

1. **Medication (Please attach a summary of the medical history with the referral or list current medication and reasons for prescription)**

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| **Referrer’s signature (Digital image files can be pasted in box to right)** |  |
| **Referrer’s name and address** |  |

Please email completed forms to Sheffield Psychosexual Therapy Service at:

psychosexualtherapyservice@shsc.nhs.uk