NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Psychosexual Medicine & Therapy Service – Referral Form

Please ensure this form is fully completed and attach any relevant additional information

Date of referral:		
Patient Name and Title:		
DOB:		
NHS Number		
Home address: **Telephone:** **Email:**	Address: Postcode: Home: Mobile:	
Referrer:	Name: Position: Agency: Address: Postcode: Telephone: Email:	
Referral type: (e.g. routine)		
GP: *(If different than above)*	Name: Practice: Address: Postcode: Telephone:	
Is GP aware of referral? If not, why not?		
Reason for referral:		
Relevant medical / surgical history: (including treatments with dates)		
Current medications:		
Recent investigations relevant to referral – please give details and results:		
Any other relevant information:		
Information which needs to be flagged e.g. risk / contact restrictions etc.:		
Please email completed form to Psychosexual.Service@mpft.nhs.uk For any queries please use the same email address or telephone 0300 7900 165 ext 7306220 or 07813400817		