**REFERRAL FOR INTRAUTERINE PROCEDURE (non-emergency)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1.REFERRER DETAILS** | | | **2.PATIENT DETAILS** | | | | |
| Name | | | Name |  | | | |
| Address | | | Date of birth |  | | | |
| Address | | | | |
| Telephone (mobile) |  | | Can we leave a voicemail? | Y N |
| Contact Numbers | | | Telephone (landline) |  | | Can we leave a voicemail? | Y N |
| Can we send correspondence? | | | | Y N |
| **3.PROCEDURE REQUIRED** *(Please select A,B or C)*  Please note: we are unable to fit IUS for a woman who is NOT requiring contraception) | | | | If patient requires a fit or a replacement please confirm the device is required for contraception. | | | |
| **A. Device fit** | | | | **B. Device replacement** | | | |
| Copper or Hormonal |  | | | Copper or Hormonal |  | | |
| Reason for referring to this service | | | | If device has expired, please detail what advice patient has been given about contraception. | | | |
| Current Contraception | | | | Reason for referring to this service | | | |
| Has patient used intrauterine contraception before? Y N | | | | | | | |
| Details of any screening tests | |  | | | | | |
| **C. Device removal** Reason for referring to this service | | | | | | | |
| Are threads visible? Y N  If not visible, has intrauterine location been confirmed with ultrasound? | | | | | | | |
| Relevant medical history |  | | | | | | |
| Medication |  | | | | | | |
| Drug Allergies |  | | | | | | |
| Additional information |  | | | | | | |

Please return this form by:

* email to [ccs.icashcambridge-referrals@nhs.net](mailto:ccs.icashcambridge-referrals@nhs.net)
* post to iCaSH, Mill House, Brookfields Hospital, 351 Mill Road, Cambridge, CB1 3DT