**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 NIf 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
* post to iCaSH, Mill House, Brookfields Hospital, 351 Mill Road, Cambridge, CB1 3DT