**Psychosexual Therapy iCaSH Bedfordshire**

**Referral Criteria and Advice   
(see referral form below)**

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| **Inclusion criteria** | **Exclusion criteria** |
| * Ejaculation Disorders * Erectile Disorder * Female Orgasmic Disorder * Sexual Desire Disorder * Vaginismus/Dyspareunia * Confusion with Gender/Trans Identity/Sexuality * Historic Child or Adult Sexual Abuse/Sexual Assault/Exploitation impacting on current intimacy * Aged 16 or above | * Complex mental health issues * Current Domestic Violence * Health Anxiety Disorder * Sex Offenders * Acute addictions requiring therapy * Current self-harm or current suicidal ideation **unless the individual is being supported concurrently by Mental Health services** |

**Referrals to the service will only be accepted:**

* After all physical causes of the sexual dysfunction have been investigated
* An appropriate treatment plan is in place for contributing organic factors
* The individual is willing to explore contextual and emotional factors

Please note: A referral does not guarantee therapy with this service. All referrals will be assessed and if appropriate, will join the waiting list. If the individual referred would like to be seen sooner, they may want to access therapy through [www.cosrt.org.uk](http://www.cosrt.org.uk)

If accepted to the service the individual or couple will be sent an opt-in form to fill in and sign. Once we receive this, they will be contacted to plan an assessment appointment. Following a joint assessment, if appropriate and agreed, six spaced follow up sessions are offered. In exceptional cases, there will be flexibility to extend the intervention for a further contract.

For further advice on preparation for referral please search ‘Referral Preparation Guidelines.’  
For further enquiries please call **01234 244126** or **0300 300 3030 Option 4**, or use the secure   
email address: [ccs.icash-bedford-kingsbrook-pst@nhs.net](mailto:ccs.icash-bedford-kingsbrook-pst@nhs.net).

To be completed by office

**Lilie No:**

**PSYCHOSEXUAL COUNSELLLING SERVICE   
REFERRAL FORM**

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| **Name of Referrer:** | **Job Role:** |
| **Referrer’s Address:**  **Contact Tel No:** | |
| **GP’s Name & Address (if not the referrer):** | |
| **Name of Client (***please double check all client details are accurate and up to date***):**  **Mr / Mrs / Miss / Ms / Rev / Dr / Other** | |
| **Date of Birth:** | |
| **NHS No:** | |
| [The person referred must be resident within Bedford Borough or Central Bedfordshire boundaries]  **Address:**  **Tel No: Mobile No: Email:**     * ***If your patient/client does not wish correspondence to be sent to the above address, please supply***   ***an alternative address or other preferred means of contact:***  …………………………………………………………………………………………………………………….  ……………………………………………………………… **Post Code:** ………………………………… | |
| **Please give a brief history of your intervention with the client to date, the reason for referral and your continued involvement:** | |

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| **Please give a brief past medical and mental health history inclusive of any suicide risk** [we can only accept the latter if the individual is under mental health supervision and they feel able to cope and consent to the challenge of therapy at this time. For Vulnerable Adults, please also provide the formal Care Plan]**:** |

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| **Please advise us of any current medications:** |
| **Details of any current attending specialists/therapists or any other referrals made at the same time as this referral** [we generally recommend one talking therapy at a time so as to avoid confusion]**:** |
| **Please advise us of the results of pre-referral screen undertaken and any subsequent treatment plan:** |
| **In discussion with the patient with their consent, please advise us of any barriers to attending for an assessment appointment that we may be able to address:**  Auditory (hearing) Yes / No  Need for interpreter, if so, preferred language? Yes / No  Mobility Yes / No  Learning difficulty Yes / No  Other:  Not applicable |
| **Signature of Referrer: Date:** |

**Please return your referral form:**

* **Via secure email to:** [**ccs.icash-bedford-kingsbrook-pst@nhs.net**](mailto:ccs.icash-bedford-kingsbrook-pst@nhs.net) **or**
* **By post to Psychosexual Therapy,** **Kings Brook, 5 St Johns Street, Bedford, MK42 0AH**

For pre-referral case advice please use the secure email (above) and we will get back to you

as soon as we can.