

## Referral Template for coils and implants

Patient Name

NHS No:

Age in years

Procedure required:

Implant In

Coil In

Implant Out

Coil Removal and re-fit  Expiration date of current coil:

Implant Out and re-fit

Type of coil e.g Mirena/Jaydess/Copper coil

Select reason(s) for referral:

- Contraception**
- Help periods** as heavy/irregular/painful (pathological causes to be ruled out prior to referral)
- Removal** of contraceptive IMPLANT only (coil removal alone not done)
- Change** of contraceptive device – implant or coil
- As part of **HRT**

Last Smear result \_\_\_\_\_

Note any significant abnormalities

Does patient consent to being registered with us as a temp resident and accessing medical record?


Relevant **PMH** e.g. Cardiac/stroke/unexplained PVB/cervical cancer/breast cancer/endometrial cancer/fibroid distorting cavity/liver tumours/active pelvic infection

Is patient at **high risk of STI**? (New sexual partner in last 12 months/Under 25) Patients will need **chlamydia** and **HVS swabs**

If pelvic pain/discharge/dyspareunia/PCB will need **chlamydia** and **HVS swabs** and **TVUS** prior to referral

Please ensure no risk of pregnancy prior to procedure and to encourage contraception with at least condoms until new form of contraception fitted.

Patient to complete:

	<b>Temporary services</b>	GMS3/99 <input type="text"/>
---	---------------------------	------------------------------

Please complete in BLOCK CAPITALS and tick  as appropriate

<b>Patient's details</b>	<b>Date if claim sent electronically</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input checked="" type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname						
<b>Date of birth</b>	First names						
NHS No. <input type="text"/>	Previous surname/s						
Home address				Temporary address, if applicable			
<input type="text"/>				<input type="text"/>			
<input type="text"/>				<input type="text"/>			
Postcode				Postcode			
<input type="text"/>				<input type="text"/>			
Telephone number				Telephone number			
<input type="text"/>				<input type="text"/>			

**Details of treatment should be sent to**  
Doctor's name and full address

**To be completed by the doctor**

<b>Emergency treatment</b>	<input type="checkbox"/> Immediately necessary treatment	<b>Contraceptive services</b>
<input type="checkbox"/> Minor surgical operation	<b>Temporary resident</b>	<input type="checkbox"/> non-IUD <input type="checkbox"/> IUD
<input type="checkbox"/> Treatment of fracture	Date of initial treatment	<b>Number of night visits</b> <input type="text"/>
<input type="checkbox"/> General anaesthetic	<input type="text"/>	<b>Dental haemorrhage</b>
<input type="checkbox"/> Reduction of dislocation	<input type="checkbox"/> up to 15 days	<input type="checkbox"/> Rate A <input type="checkbox"/> Rate B
<input type="checkbox"/> Other	<input type="checkbox"/> over 15 days	<b>Number of vaccinations &amp; immunisations</b>
<input type="checkbox"/> Telephone advice only	<input type="checkbox"/> Telephone advice only	<input type="text"/> fee A <input type="text"/> fee B
<input type="checkbox"/> Telephone advice only	<input type="checkbox"/> Amended claim	
<input type="checkbox"/> Rural practice payment. Distance in miles from patient's temporary residence to my main surgery is		<input type="text"/>

I declare to the best of my belief this information is correct and I claim the appropriate payment as in the SFA. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

<b>Authorised signature</b>	<input type="text"/>
Name	
Date	