

Referral Form for Long Acting Reversible Contraception (LARCS) Procedures

Please complete this form and post, fax or deliver it to: Cathays Surgery, 137 Cathays Terrace, Cathays, Cardiff, CF24 4HU

The surgery will contact patients directly to arrange an appointment.

Patient Name:..... DOB:.....

Patient address:.....
.....

Patient telephone number:..... Email:.....

Patient's GP name and address.....
.....

Reason for referral: (please circle as appropriate)

Contraceptive Implant: insertion or removal

Do you have any disabilities? YES/NO

If yes, please state:.....

Do you need an interpreter? YES/NO If yes, which language?.....

Past/present medical history:.....
.....

Previous pregnancies and types of delivery:.....

Current Contraception:

Current medication:.....

Any known allergies:.....

Any other relevant information:.....

How do you prefer to be contacted? (please circle as appropriate)

Letter Telephone Email Text **Can we leave a message?** YES/NO

Do you consent to us contacting your GP for further information? YES/NO

Do you consent to the sharing of your personal information between practices? YES/NO

Signed (by patient)..... Print name (patient):.....

If form is being submitted by patient's registered GP, please give the name and designation of the person completing this form.....