|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | |
| Full Name |  | | | | |
| Full Address and Postcode |  | | | | |
| Contact Number (Clients number) |  | | | | |
| Age and Date of birth |  | | | | |
| Country of Birth |  | | | | |
| Ethnicity |  | | | | |
| Gender |  | | | | |
| GP Name and Surgery |  | | | | |
| **Contact Requirements please circle as appropriate:** | | | | | |
| Text Voicemail Phone call | | | | | |
| **High Risk Groups – please tick as appropriate** | | | | | |
| Do you consider the client to be in one or more of the following high risk groups? | | Black Minority Ethnic | | |  |
| Learning Difficulties or Disabilities | | |  |
| Mental health | | |  |
| Under 25 | | |  |
| Drug and Alcohol issues (current or previous) | | |  |
| Refugee/asylums seeker/unaccompanied Child/newly arrived in the UK | | |  |
| **Please give details of the above:** | | | | | |
| **Does the client display or discuss any of the following vulnerabilities – current or historic? Please tick all that apply** | | | | | |
| Grooming (please state victim or perpetrator) | |  | Exploitation (please state victim or perpetrator) | |  |
| Power imbalance in relationship | |  | Coercion | |  |
| Aggression | |  | English not the first language | |  |
| Bullying | |  | Any type of violence or abuse | |  |
| Self-harm | |  | No fixed address/living in a hostel | |  |
| Having nonconsensual sex | |  | Being paid for/paying for sex | |  |
| Low self esteem | |  | Criminal behaviour | |  |
| LGBT | |  | Involved in social care in any way | |  |
| Isolated | |  | No positive role model or friendship group | |  |
| **Has the client undergone any assessments? If so please give details:** | |  | | | |
| **Sexual Health Information** | | | | | |
| Status of relationship (long term/casual/on-off etc) | | | |  | |
| The age of last person they had sexual contact with (please state age) | | | |  | |
| They do not feel safe – give details | | | |  | |
| How many sexual partners they have had (please state number) | | | |  | |
| **WHAT ARE YOUR SPECIFIC CONCERNS** regarding the client – this cannot be processed without completion | | | | | |
| **Risk taking behaviour – current or historic?** | | | | | |
| If yes please give details: | | | | | |
| **Clients availability (Days and times)** | | | | | |

|  |  |
| --- | --- |
| **Referrer’s Details** | |
| Name |  |
| Organisation |  |
| Contact Details |  |
| Date of referral |  |
| Did client consent to this referral |  |
| Have you discussed this referral with the client? |  |
| Have you explained your concerns to the client? |  |
| Has the client consented to the referral being made to Luton Sexual Health? |  |

**Note to professionals:**

1. Referrals will be assessed and responded to within 28 days.
2. Referring agency are responsible for identifying a suitable location for the programme to be delivered. If there is no suitable base the sessions can run from our premises in Arndale House – this needs to be a safe and confidential space within a school or other setting (Not the home of the client).
3. Please email referrals to [Andrew.trowbridge@nhs.net](mailto:Andrew.trowbridge@nhs.net)