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| **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)** |

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| **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