Name: …………………………………………………………………………………………………………………………………………………………

Date of birth: ………………………………………………………………………………………………………………………………………………

Gender: ………………………………………………………………………………………………………………………………………………………

Address: ……………………………………………………………………………………………………………………………………………………..

Post Code: …………………………………………. Contact number: ..………………………………………………………………………..

Email: …………………………………………………………………………………………………………………………………………………………

GP name: ……………………………………………………………………………………………………………………………………………………

GP address: ………………………………………………………………………………………………………………………………………………..

GP Post Code: ………………………………… GP Contact number: .............................……………………………………………

Please provide a brief description of the sexual problem:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

When did you first notice the problem? ……………………………………………………………………………………………………..

Has there been any illness, surgery or injury that you think may be relevant to the problem? Yes / No

If yes, please provide details:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Please provide details of any current medication being taken:

…………………………………………………………………………………………………………………………………………………………………..

Have any tests and checks outlined in the ‘**pre-referral screening guideline’** been carried out? Yes / No

If yes, please provide copies of results with this referral form.

Is the problem causing anxiety, low mood or distress? Yes / No

Is the problem causing difficulty in your intimate relationships, or causing you to avoid intimate relationships? Yes/No

Is there anything else you would like to mention that you think may be relevant?

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Please return to: Spire Murrayfield Hospital Wirral, Holmwood Drive, Thingwall, Wirral, CH61 1AU