# Referral Form for Long Acting Reversible Contraception (LARCS) Procedures

*Please complete this form and post, fax or deliver it to: ROATH HOUSE SURGERY*

*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

**IUD:** insertion or removal **Mirena:** 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 medication – INCLUDE CURRENT CONTRACEPTION (needs reliable contraception prior to having LARC fitted)**

**:**.....

**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.....