**Referral Template**

**NHS Ayrshire and Arran Health Board Clinic for Cervical Screening**

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| Practice and Referrer Details |  |
| Name of Practice |  |
| Practice Address |  |
| Name of Referrer |  |
| Telephone number of Referrer |  |
| Contact email address for Referrer |  |
| Patient Details |  |
| Patient Name |  |
| Patient CHI |  |
| Patient Address |  |
|  |  |
| Patient Telephone number |  |
| Reason for referral – Please tick where applicable: | * Individual with physical disability.   Please specify the physical disability:    …………………………………………     * Individual who has experienced previous trauma, including previous sexual abuse. * Individual is resident in the Priory inpatient facility. * Individual is a GP practice staff member who works in practice where they are registered as a patient. * Individual who is experiencing homelessness. |
| Please provide any further information about your patient that you feel is relevant for the service.    Information about support required for transfers, transport, whether the individual will be accompanied to the appointment, for example, is helpful. |  |