NHS
Oxford Health
NHS Foundation Trust

Contraception Outreach Nurse Referral Form

Please ensure you have read the eligibility criteria for this referral, complete form fully and return to Contraception.outreach@oxfordhealth.nhs.uk

Name of child/ young person				**Date of birth:** **NHS No:**	
Ethnicity				**Male/Female/Other**	
Name of parent/carer	**Relationship to child**			**Parental Responsibility Yes/ No** **Mobile:**	
Home address				**Telephone:** **Email:**	
GP/Doctor	Surgery/Health Centre:			**Telephone:**	
What are the identified contraception outreach needs?				**Date student informed of referral** **Date IF parent/carer informed of referral**	
Is the child subject to any of the following? **If current, please enter contact details for other agencies /professionals involved**		**Currently**	**Historically**	**Professional involved**	**Phone No**
	Child Protection Planning				
	Child in need				
	Looked after child				
	Early help assessment				
	Young carer				
	Concerns about domestic abuse at home?				
	CAMHS				
	School counsellor				
	Pastoral Support team				
	Electively Home Educated				
	Not in Education, Employment or Training				
	Child Exploitation				
	Other (please detail below)				
Additional Information					
How to contact the young person	Through school/ letter in register/ home letter/ home phone/ mobile/ email			**Method of contact agreed with young person Yes / No**	
Referrer details	Name: Role: Email: Telephone:			**Signature:** **Date:**	

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Date referral received/accepted on Carenotes	Accepted Yes/No Declined Yes/No
Referrer Informed Yes/No Letter sent Yes/No	Registered on EHR Yes/No GP informed Yes/No