**Referral for Vasectomy**

**Part A – to be completed by the referrer**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral date:** | Click here to enter a date. | **Patients name:** | Click here to enter text. |
| **Referring clinician:** | Click here to enter text. | **DOB(dd/mm/yy):** | Click here to enter text. |
| **Address:** | Click here to enter text. | **Address:** | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| **Postcode:** | Click here to enter text. | **Postcode:** | Click here to enter text. |
| **Tel No:** | Click here to enter text. | **Tel No:** | Click here to enter text. |
| **CCG Name:** | Click here to enter text. | **NHS No:** | Click here to enter text. |

|  |  |
| --- | --- |
| **Treatment will be funded by:**  | **NHS** [ ]  **Privately** [ ]  |
| **Patient referred for: Vasectomy**  | **Yes** [ ]  **No** [ ]  |
| **Significant medical history:** Click here to enter text. |

**Patient Consent**

[ ]  I (the referrer) confirm the patient has agreed that I may share their contact details with BPAS to arrange their ongoing care.

**Please note** that consent must be sought prior to the referral. Where possible please print off the form and ask the patient completes part B (overleaf) and then scan and email to bpas.referral@nhs.net

Alternatively, in the event that you are unable to print and scan this, then please use the section below to explain how patient consent has been secured e.g. in discussion during a GP clinical consultation.

|  |
| --- |
| Click here to enter text. |

To find further information on how we process personal data please visit: [**https://www.bpas.org/privacynotice/**](https://www.bpas.org/privacynotice/)

BPAS has clinics all over the country

Visit [www.bpas.org](http://www.bpas.org) to find your nearest location

**Appointments and enquiries**

**Telephone: 03457 30 40 30 (anytime)**

**Email: info@bpas.org**

**Part B – to be completed by the patient**

[ ]  I consent to my personal information being shared with BPAS to arrange vasectomy healthcare.

|  |  |
| --- | --- |
| **Print name:** | Click here to enter text. |
| **Date:** | Click here to enter a date. | **Signed:**  |  |

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You are in safe hands.

We would like to assure you that you made a good decision in choosing BPAS. We are an experienced, confidential and caring organisation.

Visit : <https://www.bpas.org/more-services-information/vasectomy/>

For information on how your information is handled please visit: <https://www.bpas.org/privacynotice/>