REFERRAL TO CCC/IUD CLINIC

CLINIC REFERRED TO:	CCC/IUD/OTHER PLEASE STATE

PATIENTS NAME AFFIX PATIENT LABEL	
DATE OF BIRTH	
ADDRESS	
CONTACT TELEPHONE NO	
OTHER INFORMATION	

DATE OF REFERRAL	
REFERRED FOR	
LMP	
LENGTH OF NORMAL CYCLE	
CURRENT CONTRACEPTION	
CURRENTLY SEXUALLY ACTIVE	YES/NO
SWABS TAKEN AND DATE	YES/NO
COUNSELLING GIVEN	
LEAFLETS GIVEN	YES/NO
OTHER CLINICAL INFORMATION	
SIGNATURE	
DOCTOR REFERRING	

APPOINTMENT DATE AND TIME	
CLINIC	

FURTHER INFORMATION

FOR USE WITH THIS REFERRAL ONLY. PLEASE DATE AND SIGN ENTRY.