Referral for Psychosexual Medicine Service

Patient Details		**Referrer details**	
Surname:		Referring Clinician:	
Forename:		Department/Speciality	
Address:		Address:	
Postcode:		Postcode:	
Home tel:		Tel:	
Daytime tel:		GP Practice name	
Date of Birth		GP address	
NHS Number:		Referred On:	

Referral criteria:

Please note that due to limited resources we only accept patients who are over 16, living at a Gloucestershire address and registered with a GP in Gloucestershire.

We will only accept following sexual dysfunctions. Please tick all that apply. We may consider other problems in exceptional circumstances and please explain these in detail in the space provided.

Erectile dysfunction		**Arousal dysfunction**	
Rapid/Delayed Ejaculation		**Orgasmic dysfunction**	
Orgasmic dysfunction		**Low desire/libido**	
Dyspareunia		**Other**	

We will not accept

1. Sexual practices which would be the subject of action under the criminal justice system

2. Sexual addictions and paraphilia

Please provide a brief history of the problem below

Significant Medical problems: (Or attach summary sheet)

Medications taken, including over the counter medications (Or attach summary sheet)

Any known history of sexual abuse or mental health concerns?

Please post to:
Sexual Health Administration Team
Hope House
Gloucestershire Royal Hospital
Great Western road
Gloucester
GL1 3NN
Or Email to: sexualhealthadministration@ghc.nhs.uk