**Referral to Pregnancy Options Advisor/Outreach Nurse**

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| --- | --- | --- | --- |
| **DATE:** | **Name Of Referrer and Agency**  **Designation:** | | |
| **Contact Number:** | | | |
| **Secure Email Address:** | | | |
|  | | | |
| **Subject of referral** | | | |
| **Name:** | | **DOB:** | |
| **Address:** | | | **Telephone Number:** |
| **School/College:** | | | **Any lone worker risks identified:** |
| **Consent given for contact:** | | |
| **If Pregnant expected date of delivery ( EDD):**  **Midwife Name :**  **Midwife Contact Number:**  **Reason for Referral& Additional information :**  **Is this Young Person currently in Safeguarding/CP/CIN/LAC(include Category for Protection Plan):**  **Name and contact details of social worker:** | | | |
| **Additional Agencies involved to date:**  **Signature/Name of Referrer:** | | | |

**South Tyneside Sexual Health Service 0191 4028168 Gateshead Sexual Health Service 01912831577**

**Return Email address**:  Secure Email for YPCN -   [stsft.sexualhealthreferrals@nhs.net](mailto:stsft.sexualhealthreferrals@nhs.net)