**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