**Logo

Description automatically generatedReferral 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](mailto: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/>