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**Luton Sexual Health Psychosexual Service**

**Referral Criteria**

* Age over 16 years
* Resident in Luton Borough

Please note we are not commissioned to provide a service for prescribing medications and other treatments for sexual dysfunction on an ongoing basis. If treatments are initiated as part of psychosexual care, ongoing prescribing will be the responsibility of the client’s GP.

Before referring men with Erectile Dysfunction, please exclude physical causes:

* Check for anabolic steroid use, smoking, alcohol and drug abuse, medication side effects
* Exclude diabetes with fasting glucose and HbA1c
* Also check lipid profile, serum testosterone (between 8 and 11 am), prolactin
* Check BP and consider Coronary Artery Disease assessment.

**We are unable to accept clients with the following issues:**

* Significant mental health issues that are impacting on sexual health function – if psychosexual issues are a small part of a wider array of mental health problems, these clients are more suitable for referral to Psychiatry in the first instance.
* Criminal sexual behaviours or fantasies – referral to Forensic Psychiatric should be made for such clients.
* Sexual addiction – please consider referring clients for CBT or Psychology input. Please see the website below for other suggested services:

<http://www.nhs.uk/Livewell/addiction/Pages/sexandloveaddiction.aspx>

* Gender identity – please refer to a specified Gender Identity Clinic, such as the services detailed below:

West London Mental Health NHS Trust Gender Identity Clinic

179-183 Fulham Palace Road, London, W6 8QZ

Telephone: 020 8483 2801

Northamptonshire Healthcare NHS Foundation Trust Gender Clinic

Danetre Hospital, London Rd, Daventry, Northamptonshire NN11 4DY

Telephone: 01327 707200

Email: genderclinic@nhft.nhs.uk



**Psychosexual Service Referral Form**

Send to: Dr J Turner, Luton Sexual Health, Luton & Dunstable Hospital, LU4 0DZ

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| --- | --- |
| **Date of referral** |  |
| **Referred by** | GP / Mental Health Services / Hospital Specialist /Other – please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Client name** |  |
| **Client DOB** |  |
| **Gender** | Male / Female / Trans / Other |
| **Address** |  |
| **Phone number** |  |
| **Consents to letters to home address?**  | Yes / No  |
| **Consents to phone calls?** | Yes / No |
| **Nature of problem** |  |
| **Duration of problem** |  |
| **Previous psychosexual or other input?** |  |
| **Relationship status** |  |
| **Partner name** |  |
| **Is partner being referred also?** | Yes / No |
| **Past medical history** |  |
| **Mental health history** |  |
| **Current involvement with services (e.g mental health, social care, health services)** |  |
| **Current medications** |  |
| **Allergies** |  |
| **Illicit drug use (inc. anabolic steroids)** |  |
| **Smoker** | Yes / Ex / Never |
| **Alcohol intake** |  |
| **Blood tests done & results** |  |
| **Any other information** |  |