**Telephone:** 0300 303 9966 **Email:** provide.wellbeing@nhs.net

***NOTE:*** This service can only be provided to patients registered with a GP in Hertfordshire (excluding West Essex patients) from whom treatment in a community setting is appropriate.

**Please tick the checkbox options represented by grey background cells.**

**Please complete this form and return by email to** **provide.wellbeing@nhs.net**

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| **Patient details** |
| NHS Number:       |
| First Name:       | Middle Name:       |
| Last Name:       |
| Address and Postcode:       |
| Date of Birth:       | Gender:       |
| Home Telephone:       | Mobile Telephone:       |
| Email:       | Ethnicity:       |
| Preferred method of contact  | **[ ]**  | **Email** | **[ ]**  | **Home telephone** | **[ ]**  | **Mobile telephone** |

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| **GP Surgery details** |
| GP Practice Name:       |
| GP Practice Address and Postcode:       |
| Telephone:       | Email:       |

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| ***Please provide as much information as possible in relation to the nature and duration of symptoms*** |
| I give my consent for sharing of relevant information between my GP and Provide Wellbeing, in relation to this referral. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I give my consent for Provide Wellbeing to contact me in relation to this referral. | **[ ]**  | **Yes** | **[ ]**  | **No** |

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| ***Please confirm the following*** |
| I understand that the sterilisation procedure is permanent and irreversible, and the reversal of sterilisation operation would not be routinely funded by the NHS. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I am certain that my family is complete, and that I do not wish to father any more children of my own. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I understand that emotional instability or feelings of uncertainty about permanent sterilisation would prevent me from undergoing a vasectomy. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I have reviewed information about the availability of alternative, long-term and effective contraceptive methods and these are either unsuitable or not my preferred method. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I understand that sterilisation does not prevent or reduce the risk of sexually transmitted infections or disease. | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I am aware that the procedure will be carried out in a community care setting under a local anaesthetic and I will be awake during the procedure. | **[ ]**  | **Yes** | **[ ]**  | **No** |

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| ***Please indicate whether the below apply to the person being referred for vasectomy:*** |
| I am under the age of 18 | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I have been diagnosed with cryptorchidism (undescended testes) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I have a history of a severe allergic reaction to local anaesthetic (e.g. anaphylaxis) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| I do not consent to undertake the procedure under local anaesthetic (awake) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| *If you have ticked yes to any of the questions in this section please visit your local GP for an assessment prior to making a referral. Surgery in the community with Provide Wellbeing may not be appropriate for you.*  |

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| ***Are you currently experiencing any of the following conditions?*** |
| Scrotal skin infection | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Active sexually transmitted disease | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Balanitis (head of the penis is swollen and sore) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Epididymitis (inflammation of the tube carrying sperm to the testes) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Orchitis (inflammation of one or both testicles) | **[ ]**  | **Yes** | **[ ]**  | **No** |

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| ***Have you ever been diagnosed with any of the following conditions?*** |
| History of testicular or scrotal surgery or abnormality | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Hydrocele (swelling in the scrotum that occurs when fluid collects in the thin sheath surrounding a testicle.) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Large spermatocele (abnormal sac (cyst) that develops in the epididymis — the small, coiled tube located on the upper testicle that collects and transports sperm) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Inguinal hernia (tissue, such as part of the intestine, protrudes through a weak spot in the lower abdominal muscles) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Extreme Scrotal Hypersensitivity | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Small tight scrotum/brisk cremasteric reflex | **[ ]**  | **Yes** | **[ ]**  | **No** |
| *If you have ticked yes to any of the questions in this section, please ask for a face-to-face assessment when you are contacted to book a pre-procedure assessment with Provide Wellbeing.* |

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| ***Please provide as much information as possible in relation to the nature and duration of symptoms*** |
| Are you a recreational drug user? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Are you consuming a high level of alcohol (above 14 units per week - equivalent to 6 pints of average-strength beer or 10 small glasses of low-strength wine)? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Are you taking any medication for anticoagulant/anti-platelet therapy (drugs to thin the blood)? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Do you have any known allergies or sensitivities (e.g. drugs, latex, anaesthetic, others) | **[ ]**  | **Yes** | **[ ]**  | **No** |

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| Have you had any previous adverse reactions to procedures (e.g. fainting or seizures)? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Are you taking any medication/drugs? (prescription, non-prescription or recreational) | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Have you ever been treated for cancer? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Do you have a pacemaker? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Have you been diagnosed with diabetes? | **[ ]**  | **Yes** | **[ ]**  | **No** |
| Do you have any mental health conditions? | **[ ]**  | **Yes** | **[ ]**  | **No** |

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| **Patient Information / Medical Information** |
| Marital Status:       | Occupation:       |
| Number of own Children:       | Number of stepchildren:       |
| Type of Work  | **[ ]**  | **Physical Work** | **[ ]**  | **Non-physical Work** | **[ ]**  | **No Work** |
| Height:       | Weight:       |
| BMI (Optional):       |
| Past Medical History:       |
| Current Medication:       |
| Allergies or Sensitivities:       |

**Please complete this form and return by email to** **provide.wellbeing@nhs.net**