**Telephone:** 0300 303 9966 **Email:** [provide.wellbeing@nhs.net](mailto: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**](mailto:provide.wellbeing@nhs.net)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | |

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