**HANHAM VASECTOMY SERVICE REFERRAL FORM**

**Completed form to be emailed to:** [bnssg.hvs@nhs.net](mailto:bnssg.hvs@nhs.net)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname:** |  | | | | **Forename:** | |  | | |
| **Date of Birth:** |  | **Age:** | | |  | **NHS Number:** | | |  |
| **Address:** |  | | | | | | | | |
| **Tel Home:** |  | | **Mobile:** |  | | | **Email:** |  | |
| **Name and Address of GP:** |  | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **How Long has the patient been considering a vasectomy?** |  | |
| **Understands vasectomy is a permanent form of contraception?** | Yes | No |
| **Is the patient certain that his family is complete?** | Yes | No |
| **Agrees to have procedure under local anaesthetic?** | Yes | No |
| **Current partner/wife?** | Yes | No |
| **Vasectomy discussed with partner (if applicable)?** | Yes | No |
| **Does the patient have children?** | Yes | No |
| Please list ages: | |
| **Current contraception used?** |  | |
| **Has the patient considered other forms of contraception?** | Yes | No |

**Checklist:**

|  |  |  |
| --- | --- | --- |
| **History of abdominal, groin or testicular surgery (eg hernias, orchidopexy)?** | Yes | No |
| **If yes, please give details:** | | |
| **History of genital problems (eg cysts, hydrocele, infections or chronic pain)?** | Yes | No |
| **If yes, please give details:** | | |
| **Is the patient taking anticoagulant or antiplatelet medication?** | Yes | No |
| **If yes, please give details:** | | |
| **Does the patient have a pacemaker or internal cardiac defibrillator?** | Yes | No |
| **Has the patient had a local anaesthetic previously?** | Yes | No |
| **If yes, any adverse reaction to local anaesthetic?** | | |
| **Is the patient of sound mental capacity for making the decision, as emotional instability or equivocal feelings about permanent sterilisation are contraindications to vasectomy?** | Yes | No |
| **Does the patient understand that sterilisation does not prevent or reduce the risk of sexually transmitted infections?** | Yes | No |
| **Does the patient understand that they will receive an initial appointment for counselling to discuss availability of alternative, long-term and highly effective contraceptive methods?** | Yes | No |

**Additional Details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Weight:** |  | | **Height:** |  | **BMI:** |  |
| **Current Medication:** | |  | | | | |
| **Allergies:** | |  | | | | |
| **Previous Medical History:** | |  | | | | |