City Health Care Partnership

SELF REFERRAL FOR ERECTILE DYSFUNCTION

This form will enable any men living in Hull and East Riding of Yorkshire to access the Erectile Dysfunction Service (part of the Hull and East Riding Sexual and Reproductive Healthcare Partnership).

Please complete the form and send it to: **Erectile Dysfunction Service, Genitourinary Medicine Department, Entrance 2, Castle Hill Hospital, Castle Road, Cottingham, HU16 5JQ** and we will be in touch to discuss your concerns and possible treatment options.

Today's Date:_____

Name: _____ Date of Birth: _____

Address: _____ Home telephone: _____

_____ Mobile Number: _____

_____ Email: _____

Postcode: _____

GP Name and address:_____

It is our policy to involve your GP to ensure safe treatment and care.

If you do not wish your GP to be contacted please state why:_____

Please state why you feel you need this appointment:

Erectile Dysfunction: ☐ Yes ☐ No

Premature Ejaculation: ☐ Yes ☐ No

Other (please state): _____

Do you have any disabilities? ☐ Yes ☐ No

If yes, please state: _____

Do you need an interpreter? ☐ Yes ☐ No If yes, which language: _____

Past or present health problems and/or medication: _____

_____

Any known allergies:_____

How can we contact you?

☐ Letter ☐ Mobile Telephone ☐ Email

☐ Text ☐ Home Telephone

Can we leave a message:

Mobile Telephone ☐ Yes ☐ No

Home Telephone ☐ Yes ☐ No

What is the best time to contact you? *(Please circle one)* Morning Afternoon Both

How did you hear about our service?

☐ GP ☐ Specialist nurse ☐ Friends ☐ Family

☐ Leaflet ☐ Poster ☐ Website ☐ Other_____

WHEN CONTACTING A PATIENT WE WILL ONLY TRY 3 TIMES AND THEN THE PATIENT WILL BE DISCHARGED

TELEPHONE CALLS WILL COME FROM A WITHHELD NUMBER