

Referral for Vasectomy



British Pregnancy Advisory Service

Part A – to be completed by the referrer

Referral date:		Patients name:	
Referring clinician:		DOB(dd/mm/yy):	
Address:		Address:	
Postcode:		Postcode:	
Tel No:		Tel No:	
CCG Name:		NHS No:	

Treatment will be funded by:	NHS <input type="checkbox"/> Privately <input type="checkbox"/>
Patient referred for: Vasectomy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Significant medical history:	

Patient Consent

I (the referrer) confirm the patient has agreed that I may share their contact details with BPAS to arrange their ongoing care.

Please note that consent must be sought prior to the referral. Where possible please print off the form and ask the patient completes part B (overleaf) and then scan and email to bpas.referral@nhs.net

Alternatively, in the event that you are unable to print and scan this, then please use the section below to explain how patient consent has been secured e.g. in discussion during a GP clinical consultation.

To find further information on how we process personal data please visit:

<https://www.bpas.org/privacynotice/>

BPAS has clinics all over the country
Visit www.bpas.org to find your nearest location

Appointments and enquiries
Telephone: 03457 30 40 30 (anytime)
Email: info@bpas.org

Part B – to be completed by the patient

I consent to my personal information being shared with BPAS to arrange vasectomy healthcare.

Print name:			
Date:		Signed:	

You are in safe hands.

We would like to assure you that you made a good decision in choosing BPAS. We are an experienced, confidential and caring organisation.

Visit : <https://www.bpas.org/more-services-information/vasectomy/>

For information on how your information is handled please visit: <https://www.bpas.org/privacynotice/>