Peninsula Health
Sexual and Reproductive Health

LONG ACTING REVERSIBLE CONTRACEPTION REFERRAL (IUD's and Implanon NXT)

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.24/4/25 Print Code:14229

PHF055350X

Referral to: ☐ **Dr Nisha Khot** Provider No: 4407249X

FAX: 9125 9846 *If Urgent ring: 0466 453 003*

Referral Date ...../...../..... Contact no: .....

Patient Name: ..... Pronouns: .....

Patient's Address .....

Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Referring Clinician

Clinician Name ..... Provider Number .....

Address ..... Signature .....

Contact number ..... FAX number .....

Reason for Referral (please tick)

☐ Contraception ☐ Management of Heavy Menstrual Bleeding (HMB) Ultrasound report: ☐ Yes ☐ No

☐ Intrauterine Device ☐ Implanon NXT ☐ Results pending

Obstetric / Gynaecological History

Current Contraception .....

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Pregnancies: G ..... P ..... Mode of Delivery .....

.....

Last cervical screening test ..... ☐ To be done at appointment

Last STI screening ..... ☐ To be done at appointment

Additional comments: .....

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Contraceptive choice ☐ Hormonal IUD ☐ Non hormonal IUD ☐ Implanon NXT ☐ Undecided

Has script ☐ Yes ☐ No

Fax form to 9125 9846

Client will be contacted by phone to book an appointment

Client Signature: ..... Print Name: .....

LONG ACTING REVERSIBLE CONTRACEPTION REFERRAL MR/055350

24/4/25 Print Code:14229 GP liaison version