

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.2/11/2023 Print Code:14229

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

FAX: 9788-1879 *If Urgent ring: 0466 453 003 email: srhs@phcn.vic.gov.au*

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 .....

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: .....

Contraceptive choice  Hormonal IUD  Non hormonal IUD  Implanon NXT  Undecided

Has script  Yes  No

**Fax form to 97881879**

Client will be contacted by phone to book an appointment

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

