

RUClear fax No: 0161 230 2691

CRN:  
.....

### Sexual Health Centre - Fast Track Referral Form

Date: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Postcode \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Reason for referral (Please tick all that apply)

GC Positive  Symptomatic

CT Positive  CT Negative

Preferred method of contact: **PHONE CALL**  **LETTER**   
(Please tick)

 To be completed by sexual health centre, detached and Faxed to 0161 230 2691  
RU Clear operates safe haven fax procedures .

Patient Name: \_\_\_\_\_

CRN:  
.....

Patient seen by: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Date of treatment: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Confirm GC Status \_\_\_\_\_ Sensitivity: \_\_\_\_\_

Patient did not attend, was recalled  times