*Please complete this form and post via internal mail to: Woodlands Medical Centre, Greenfarm Road, Ely, Cardiff. CF5 4RG. Telephone: 02920 591444 Fax 02920 599204*

*Woodlands Medical Centre will contact patients directly to arrange an appointment.*

**Patient Name** :

**Date Of Birth**:

**Patient address:**.

**Patient telephone number:**..............................................

**Email:**.................................................................................

**Patient’s GP name and address**:

Dr AM Stone & Partners, Meddygfa Canna Surgery,

27 Wyndham Crescent, Canton, Cardiff. CF11 9EE

**Reason for referral: (please circle as appropriate)**

**Contraceptive Implant:** insertion or removal

**IUD:** insertion or removal **Mirena:** insertion or removal

**Do you have any disabilities?** YES/NO

If yes, please state:.....................................................................................................................

....................................................................................................................................................

**Do you need an interpreter?** YES/NO If yes, which language?............................

**Past/present medical history:**..................................................................................................

....................................................................................................................................................

**Previous pregnancies and types of delivery:**.........................................................................

**Current medication:**..................................................................................................................

**Any known allergies:**................................................................................................................

**Any other relevant information:**..............................................................................................

**How do you prefer to be contacted?** (please circle as appropriate)

Letter Telephone Email Text **Can we leave a message?**  YES/NO

**Do you consent to us contacting your GP for further information? YES/NO**

**Do you consent to the sharing of your personal information between practices? YES/NO**

Signed (by patient)................................. .......Print name (patient):........................................

If form is being submitted by patient’s registered GP, please give the name and designation

of the person completing this form..........................................................................................