*Please complete this form and post, email or deliver it to: Woodlands Medical Centre, 1 Greenfarm Road, Ely, Cardiff CF5 4RG* [*receptionteam.w97023@wales.nhs.uk*](mailto:receptionteam.w97023@wales.nhs.uk)

*The surgery will contact patients directly to arrange an appointment.*

**Patient Name**:...................................................................... **DOB**:...............................................

**Patient address:**..........................................................................................................................

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

**Patient’s GP name and address**................................................................................................

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**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:**..................................................................................................

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**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..........................................................................................