



**Erectile Dysfunction Referral Form for Health Professionals**

Referral Source:  
(Specialist Team)

Copy of referral to GP.....  Yes  No  Declined

**Patient Details**

Name:

Date of Birth:

Address:

Home Number:

Postcode:

Mobile Number:

GP:

Brief history of erectile dysfunction:

Past and current medical conditions:

Current Medication:

Previous treatments for erectile dysfunction:  No  Yes (If yes details)

**Please identify patients preferred choice of communication:**

Letter

Mobile Telephone

Email

Text

Home Telephone

Email Address:

Please send referrals to the following address:

**GUM Department, Castle Hill Hospital, Castle Road, Cottingham, HU16 5JQ.**

**Referral form can also be accessed from our Website:**

**[www.luvhull.co.uk](http://www.luvhull.co.uk) / [www.luveyorks.co.uk](http://www.luveyorks.co.uk)**