

SEXUAL HEALTH SERVICES

National Referral Recommendations

SPECIFIC SEXUAL HEALTH SERVICES REFERRAL LETTER GUIDELINES

- Referrals can be accepted from individual patients (Self referral).
- How the patient wishes to be contacted.
- Whether the patient wishes to be contacted or will contact the service [referrer to check].
- Referrer contact details/and GPs details if patient agrees.

NATIONAL REFERRAL GUIDELINES : SEXUAL HEALTH SERVICES

Diagnosis	Evaluation	Management Options	Referral Guidelines
<p>People may raise sexual health issues in the context of:</p> <ul style="list-style-type: none"> • Asymptomatic screening • Adult / Child Sexual Abuse • Common symptomatology • Sexual health advice 	<p>Thorough history, including sexual history, and examination are required for all cases.</p> <p>Screen for all STDs noting local prevalences.</p> <p>Screening for women must include endocervical swab for gonorrhoea, and chlamydia tests and high vaginal swab for Candida, bacterial vaginosis and trichomonas. Ensure cervical screening up to date</p> <p>[Note: Cervical cytology will not reliably identify all STDs]</p> <p>Screening for men should include a meatal swab for gonorrhoea and either a urethral swab for chlamydia or a first catch urine test.</p> <p>Treatment of partners without screening is not recommended.</p> <p>[Note: Screening for chlamydia in anyone under 26 years of age with more than one sexual partner in the previous 6 months is advised].</p> <p>Chlamydia tests: depending on local lab should include an endocervical swab or a first catch urine/urethral swab.</p>	<p>Sexual Health Clinics offer free diagnosis and treatment in a confidential setting. In particular key points for adolescents:</p> <ul style="list-style-type: none"> • neither adults or children, • confidentiality • safety issues. <p>Any treatment must include screening and treatment of partner(s).</p> <p>All testing requires informed consent.</p> <p>[Note: MoH Publication "Consent in Child and Youth Health: Information for Practitioners"].</p> <p>Discuss options with local laboratories or Sexual Health Clinic.</p> <p>[Note: there may be local/regional variations in tests for chlamydia]</p>	<p>Circumstances for discussion and/or referral are indicated below with reference to appropriate specialty/ specialties (suicide and at risk behaviour).</p> <p>It is to be noted that most patients self refer to Sexual Health services.</p> <p>[Note: If patient does not contact the service/or fails to attend, then the referrer will be contacted within one month]</p> <p>It should be recognised that the issues raised may be complex and individual practitioners may wish to refer earlier than indicated in these guidelines.</p>

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CERVICAL DYSPLASIA (CIN)	<p>HISTORY:</p> <ul style="list-style-type: none"> • Intermenstrual bleeding • Post coital bleeding • Smoking • Sexually transmitted diseases • Previous cervical smear history <p>Evaluation:</p> <ul style="list-style-type: none"> • Visualise cervix <p>Investigation:</p> <ul style="list-style-type: none"> • Cervical smear • Consider screening for STDs 	<ul style="list-style-type: none"> • Treat infections <p>Advise re:</p> <ul style="list-style-type: none"> • Stop Smoking, • Safer sex 	<p>See attached Flow charts. Refer to: 'Guidelines for the Management of Women with Abnormal Cervical Smears' Sept 1998. Published by the HFA for the National Cervical Screening Programme.</p>

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Action Plan For Cervical Smear Results

SMEAR RESULT	SMEAR HISTORY	ACTION	
1. NORMAL OR BENIGN/REACTIVE CHANGES	Satisfactory	Previous normal smears	Smear in 3 years
		First smear, or more than 5 years since last smear	Smear in 1 year
		Previous abnormal smears	Refer to flow chart
Satisfactory but limited*	Previous normal smears	Smear in 1 year	
	First smear, or more than five years since last smear	Smear in 1 year	
	Abnormal smear in last five years	Smear in 6 months	
Unsatisfactory Smear		Smear in 1-3 months	

* Except absent endocervical/metaplastic cells – in which case; if the cervix has been visualised and adequately sampled and there is no other indication to repeat the smear earlier, repeat the smear in three years.

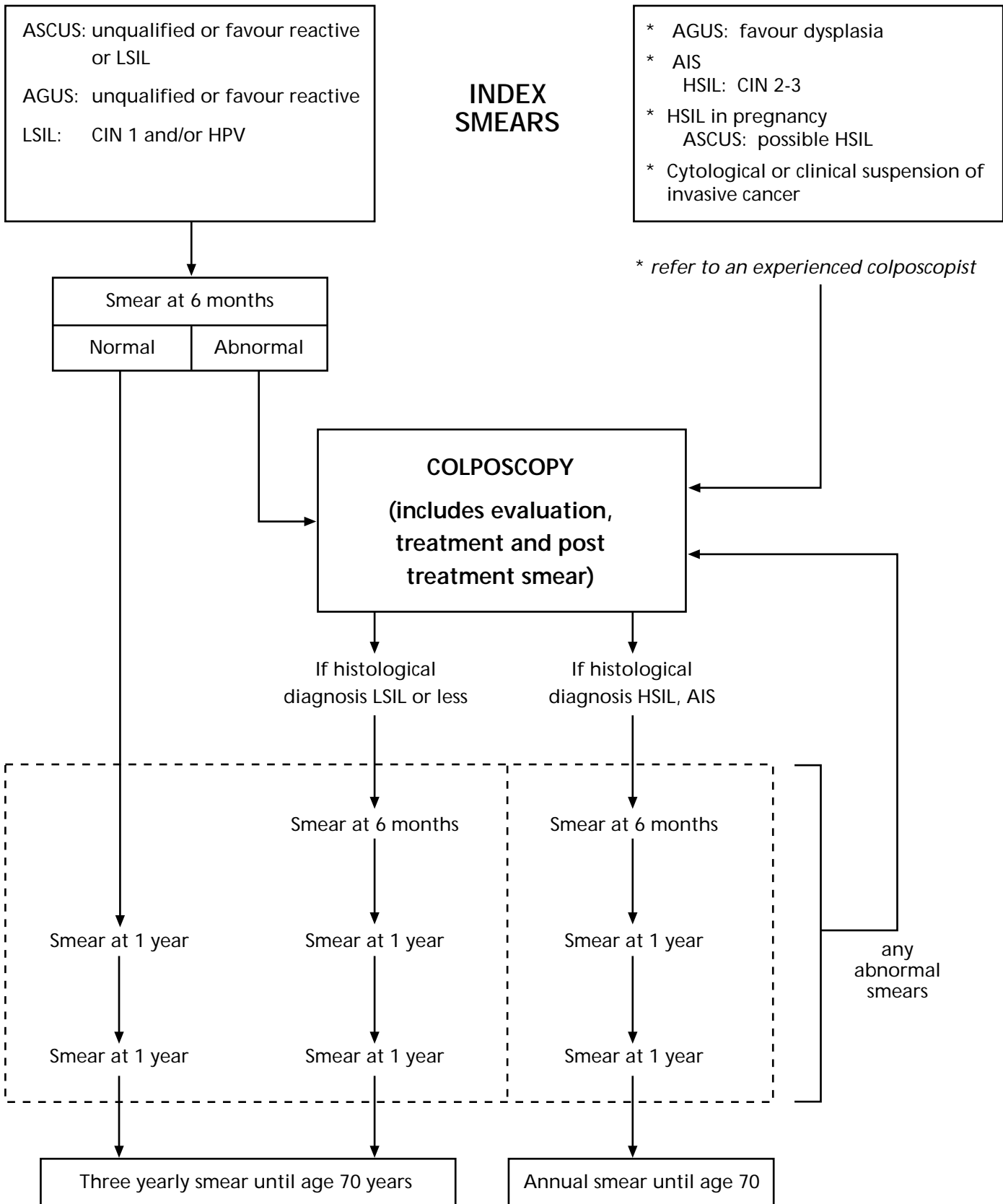
2. ABNORMAL

Ascus: unqualified or favour reactive or LSIL AGUS: unqualified or favour reactive LSIL: CIN 1 and/or HPV	Previous normal Smears	Smear in 6 months
	Previous abnormal smear	Refer to flow chart
* AGUS: favour dysplasia * AIS HSIL: CIN 2-3 * HSIL in pregnancy ASCUS: possible HSIL * Suspicious or diagnostic of invasive carcinoma		

* Refer to an experienced colposcopist

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Management of the Abnormal Smear



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ASYMPTOMATIC SCREENING	<p>KEY POINTS:</p> <p>Sexual history including risk factors for HIV.</p> <p>For example:</p> <ul style="list-style-type: none"> • Men who have sex with men • Injecting drug users (IDU) including steroid users • Sex workers • Overseas sexual partner • Blood transfusion/ products pre 1985 or overseas • Partners of any of the above • HIV positive partner <p>Investigations:</p> <ul style="list-style-type: none"> • HIV antibodies 3-6 months after at risk exposure/ behaviour <p>Note: Pre test discussion would include areas such as window period, significance of positive and negative results and legal consequences.</p> <p>Delivery of results in person by person ordering the test.</p>	<p>Negative results:</p> <ul style="list-style-type: none"> • Patient counselled re safer sex behaviour. Remember the 3-6 month window period. <p>Indeterminate results:</p> <ul style="list-style-type: none"> • Discuss with Sexual Health Clinic <p>Positive results:</p> <ul style="list-style-type: none"> • Repeat test on second blood sample • A positive Elisa must be confirmed by Western Blot before informing patient • Discuss with Sexual Health Clinic or Infectious Diseases physician/other HIV/AIDS specialist • Refer MoH guidelines "Management Guidelines:HIV/AIDS" June 1998 appendix 1 page 32 <p>Note: The AIDS Medical and Technical Advisory Committee (AMTAC) recommends the following for antenatal screening:</p> <p>Pregnant women and their sexual partner(s) should routinely be screened for HIV risk behaviours. Those screening positive for lifestyle factors should then be offered pre-test counselling and then tested for HIV.</p> <p>Women who are identified as being HIV positive during pregnancy should be offered Zidovudine during pregnancy and labour, the infant treated for 6 weeks post partum and the mother advised against breastfeeding.</p>	<p>Refer to Sexual Health for advice including management and contact tracing.</p> <p>(Note: in some localities HIV contact tracing is co-ordinated by the HIV specialist physician)</p> <p>Refer to NZ AIDS Foundation specialist counselling and support services where appropriate/available</p>
HIV testing			

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Screening for sex industry workers	<p>KEY POINTS:</p> <ul style="list-style-type: none"> • Three monthly evaluation recommended with screening as outlined previously. 	<p>Available at Sexual Health Clinic:</p> <ul style="list-style-type: none"> • Hepatitis B immunisation • Condoms • Information about NZ Prostitutes' Collective 	<p>Most self-refer to Sexual Health Clinics.</p>
<p>Antenatal screening</p> <p>[Note: all providers of maternity services, including midwives and hospital antenatal clinics should consider this Referral Guideline]</p>	<p>KEY POINTS:</p> <p>Identify those at risk. For example:</p> <ul style="list-style-type: none"> • Women < 26 years • Recent partner change • High local prevalence of STDs • Previous history of STDs <p>Sexual history is important</p> <p>Screening as outlined previously during first trimester and repeat at 36 weeks if there is continuing risk.</p>	<p>Treatment depends on diagnosis and must include treatment of partner(s) where appropriate.</p> <p>[Note: only 20% of those infected with herpes simplex type 2 virus are aware of their diagnosis and 80% of neonatal herpes cases occur without prior known history of parental herpes. Where possible, all women should be examined at the onset of labour for herpes lesions].</p>	<p>Discuss with Sexual Health Clinic:</p> <ul style="list-style-type: none"> • Safe treatment options in pregnancy • Gonorrhoea management • Contact tracing • Herpes management • Positive syphilis serology • HIV management • Bacterial vaginosis <p>See New Zealand Herpes Foundation Guidelines. Discuss positive findings with specialist obstetrician.</p>
TOP screening or IUCD insertion	<p>KEY POINTS:</p> <ul style="list-style-type: none"> • All patients should be screened as outlined previously prior to procedure. 	<ul style="list-style-type: none"> • Treatment and contact tracing as appropriate prior to procedure. 	

Version 1 Sexual Health Services Referral Guidelines and Priorisation Criteria • Date: 21/5/2001 • Authorised: Elective Services, HFA

NATIONAL REFERRAL GUIDELINES : SEXUAL HEALTH SERVICES			
Diagnosis	Evaluation	Management Options	Referral Guidelines
<p>COMMON SYMPTOMATOLOGY</p> <p>Dysuria/discharge in men</p>	<p>KEY POINTS:</p> <ul style="list-style-type: none"> Sexual history is important Men should not pass urine for 2-3 hours prior to examination. Screening for men should include a meatal swab for gonorrhoea and either a urethral swab for chlamydia or a first catch urine test. 	<ul style="list-style-type: none"> For gonorrhoea discuss with Sexual Health Clinic. For chlamydia – Azithromycin 1.0G stat preferably given as directly observed therapy For non-specific urethritis Doxycycline 100 mgs B.D. or Minomycin 50 mgs BD for 7-10 days. Contact tracing (partner screening and treatment) is essential and may be accessed through local Sexual Health Clinic. 	<ul style="list-style-type: none"> Refer cases that do not respond to treatment. Complex contact tracing
<p>Genital conditions (Note: not all bumps are warts and not all ulcers are herpes)</p>	<p>KEY POINTS:</p> <p>A good light should be used to examine each person.</p> <p>Common conditions include:</p> <ul style="list-style-type: none"> Genital warts Genital herpes Tinea cruris Lichen simplex Psoriasis Scabies Pubic lice Molluscum contagiosum Non-specific balanitis <p>Investigations:</p> <ul style="list-style-type: none"> Viral swab for genital herpes Screening for other STDs if appropriate Skin scrappings if suspect tinea infection Consider dermatological referral for possible skin biopsy 	<p>Treat as appropriate. (c.f. Dermatology Referral Protocols)</p> <p>Genital Herpes:</p> <p>Oral Acyclovir/Zovirax for first episode. Consider Prophylactic Acyclovir for recurrent episodes. Refer New Zealand Herpes Foundation Guidelines.</p> <p>Genital Warts:</p> <p>Treatment options include; Condyline b.d. for 3 days, 4 week cycles, cryotherapy weekly until treatment completed, diathermy. [Imiquomod (available) –non-subsidised treatment]. Do not use Condyline or Podophyllin in pregnancy.</p> <p>For women, refer to National Cervical Screening Guidelines.</p>	<p>Refer rashes that are not responding to treatment or if diagnosis uncertain to relevant specialty depending on local access.</p> <p>Genital herpes not responding to treatment or with psychosexual issues should be referred to Sexual Health Clinic.</p> <p>Genital warts not responding to treatment by GP are best referred to a Sexual Health Clinic.</p>

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VAGINAL DISCHARGE c.f. Gynaecology Referral Recommendations	<p>KEY POINTS:</p> <p>Full history and vaginal examination are essential.</p> <p>Common causes include:</p> <ul style="list-style-type: none"> • Physiological • Candida/thrush • Bacterial vaginosis • Trichomonas • Retained tampon/condom • CIN and neoplasia • Cervicitis: <ul style="list-style-type: none"> - herpetic } - chlamydial } - gonococcal } - non-specific } <p>Note: Bacterial vaginosis is as common as thrush.</p> <p>Investigations:</p> <ul style="list-style-type: none"> • See previous screening • Cervical cytology if due • Blood glucose if recurrent Candida. 	<p>Physiological – counselling and education.</p> <p>Candida: Tropical azole eg Clotrimazole.</p> <p>Recurrent: Tropical Azole course premenstrually for 3 months or oral medications e.g. Fluconazole or Itraconazole.</p> <p>Asymptomatic culture findings of Candida or gardnerella do not require treatment.</p> <p>Sexual partners of those with trichomonas should be treated in all cases.</p> <p>STD's – treat patient and partner. Referral to STD clinic for contact tracing and counselling.</p>	<p>Refer non-responding or recurrent cases to Sexual Health Clinic.</p> <p>Refer to gynaecology service:</p> <ol style="list-style-type: none"> 1. Refer those women with copious physiological discharge and a wide ectropion for cryotherapy. 2. Unexplained post menopausal discharge.

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<p>Abdominal pain cross-refer to Gynaecology Referral Recommendations for Pelvic Inflammatory Disease</p>	<p>KEY POINTS: Sexual history is important.</p> <ul style="list-style-type: none"> • Symptomatology – pain, discharge, pyrexia • Out of phase bleeding • ?presence of IUCD <p>Investigations:</p> <ul style="list-style-type: none"> • FBC/ESR • HVS/Chlamydia swab • Endocx/urethral/rectal swab • HCG • Cervical cytology 	<ul style="list-style-type: none"> • Antibiotics for PIDs, noting local resistance patterns • Link and liaise with STD clinic as appropriate • Screen and treat sexual partners. 	<p>Consider for admission:</p> <ul style="list-style-type: none"> • Unresponsive to treatment(48-72 hours). • Positive pregnancy test with pelvic pain + - fever. • Diagnosis uncertain • Pelvic abscess suspected • Severe nausea and vomiting • Adolescent • Compliance not assured • HIV positive
<p>Epididymo-orchitis cross-refer to Urology Referral Recommendations</p>	<p>KEY POINTS: Sexual history is important. Consider the following conditions:</p> <ul style="list-style-type: none"> • Torsion – important to exclude • Trauma • Bacterial: <ul style="list-style-type: none"> – Chlamydia - the most common cause in men under 35 – E.Coli – the most common cause in men over 35 – Gonorrhoea – TB • Neoplasia – any suspicion always warrants further investigation • Viral infections, e.g. mumps <p>Investigations: Consider -</p> <ul style="list-style-type: none"> • Urethral swab for gonorrhoea and either swab or first catch urine for chlamydia • MSU • Ultrasound scan 	<p>For men under 35 with evidence of urethritis give Doxycycline 100 mgs for 14-21 days. Screen and treat sexual partners.</p> <p>For men over 35 give Ciprofloxacin 500 mg BD for 14-21 days or Augmentin 500 mg TDS for 14-21 days. All treatment should be reviewed to ensure adequate response.</p>	<p>If any doubt regarding torsion immediate referral for surgical assessment is mandatory.</p> <p>Gonococcal epididymitis should be referred to Sexual Health Clinic.</p>

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<p>URINARY SYMPTOMS</p> <p>(See Gynaecology Urology referral recommendations)</p>	<ul style="list-style-type: none"> • UROLOGICAL HISTORY <ul style="list-style-type: none"> - stress, urge incontinence - frequency, nocturia, enuresis - voiding difficulty (hesitancy) - Haematuria dysuria • GYNAECOLOGICAL HISTORY (Prolapse Symptoms) • Medical/Drug History • Previous Gynaecological/Obstetric History • Abdominal/Pelvic/Neurological Exam <p>INVESTIGATIONS:</p> <ul style="list-style-type: none"> • MSU/Urinalysis (if infected treat and reassess) • Urinary Diary • Assess Post Void Residual • (Physical exam/ catheterization/ ultrasound) 	<ol style="list-style-type: none"> 1. Lifestyle Interventions (decrease caffeine, weight and smoking; treat constipation: appropriate fluid intake). 2. Pelvic Floor Muscle Training (PFMT) and Bladder Retaining by trained continence therapist for 3/12. 3. Local Oestrogens/HRT if postmenopausal. 4. Trial of Bladder Relaxants if presumed overactive bladder (and no significant post void residual) 	<p>Referral to Gynaecological or Urological Service in the following circumstances:</p> <ul style="list-style-type: none"> • Failed conservative treatment (PFMT and Bladder retraining) • Complex History eg: <ul style="list-style-type: none"> - Recurrent incontinence - Incontinence associated with: • Pain • Haematuria • Recurrent Infection • Voiding symptoms • Pelvic irradiation • Radical pelvic surgery • Suspected fistula <ul style="list-style-type: none"> - Significant Post Void Residual • Significant Pelvic Organ Prolapse

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Diagnosis	Evaluation	Management Options	Referral Guidelines
SEXUAL HEALTH ADVICE	<p>KEY POINTS:</p> <ul style="list-style-type: none"> Identify at risk behaviour, e.g. frequent partner change, lack of barrier contraception, same sex partner + behaviour change Identify triggers for at risk behaviour, e.g. alcohol, drug abuse, past or current sexual or physical abuse Potential for behavioural change Offer STD screening as previously described Consider contraception requirements. Possible pregnancy testing. 	<p>Treat any underlying disease.</p> <p>[Note: Condoms available on MPSO or free from Sexual Health Clinics]</p>	<p>Refer to Sexual Health Clinic for sexual counselling advice or refer to appropriate agency e.g. Drug and Alcohol Centre/Family Planning/Youth Clinic.</p>
Sexual Issues such as Impotence/Sexual Dysfunction as may present to Sexual H.C.	<p>History and examination for impotence; considerations of physical and psychological causes.</p> <p>Erectile dysfunction Investigations – for example</p> <ul style="list-style-type: none"> CBC blood sugar testosteroneFree Androgen Index blood lipids LFTs 	<p>All men who experience erectile dysfunction will have psychological issues. However, underlying physical causes should be treated e.g. diabetes, medication, alcohol, neurological or vascular conditions.</p> <p>Treat if appropriate e.g. Viagra or refer to other specialist/colleagues i.e. Urologist, Endocrinologist, Gynaecologist, Psychotherapist or Sex Therapist.</p>	<p>Consider referral of those not suitable for or those not responding to first time therapy dysfunction to local specialist sexual dysfunction service for outpatient assessment.</p>

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Diagnosis	Evaluation	Management Options	Referral Guidelines
CHILD SEXUAL ABUSE May be associated with other forms of abuse such as physical, emotional or neglect.	Key Points <ul style="list-style-type: none"> • Acute Assault within last seven days • Genital / Genital Contact • Pain, bleeding or discharge • Concerns re safety of child and ? others at risk • -Do not examine child in detail • Take the briefest history needed to establish that: <ul style="list-style-type: none"> - the concern relates to sexual abuse - the approximate time of the most recent episode - symptoms to help the person you refer to decide how urgent the examination needs to be done. - Assess ability of caregiver (non abuser) to keep child safe and act in interest of the child 	Acute Assault <ul style="list-style-type: none"> • Do not attempt genital swabs or forensic samples • If child has not washed or changed clothing since the last episode of contact abuse they should not do so until formally examined. • Refer immediately. <p>Never feel that you have to deal with this alone. Share decision process with colleague or local DSAC representative and always put child's needs first.</p>	Acute Assault <p>All acute assaults need urgent referral on the day they present. And should be seen immediately if there is:</p> <ul style="list-style-type: none"> • Acute anogenital symptoms/injuries • Acute abdominal pain • Sexual assault within last 7 days • Pregnancy or Sexually Transmitted Disease suspected. <p>Liase with Paediatric assessment services at nearest hospital</p> <p>Or</p> <p>Liase with DSAC representative for your area if unsure of options.</p> <p>Liase with local child protective agencies eg care and protection within CYPS</p> <p>Or Liase with local Police sexual assault unit</p>
	If non acute assault ie more than seven days <ul style="list-style-type: none"> • Check ability of caregiver(non abuser) to keep child safe • Ask about Pain/ bleeding or discharge 	Non acute assault <p>If no medical Symptoms</p> <ul style="list-style-type: none"> • needs appropriate investigation according to age • needs to be kept safe from on going abuse. <p>Refer immediately especially if any concerns re ongoing safety.</p> <p>NB all children suspected of sexual abuse should be offered an expert medical examination to reassure them that their bodies are healthy and to detect asymptomatic STD's.</p>	Non acute assault <p>Refer urgently for medical assessment if any symptoms as above.</p> <p>Or Refer to local child protective agency eg CYPS or to Police Sexual Assault team to ensure safety and access to appropriate investigation process.</p>

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<p>CHILD SEXUAL ABUSE</p> <p>Concerns re possible sexual abuse of a child</p>	<p>Concerns raised by caregiver/relative?</p> <p>Check why they are concerned- history from child, behaviour or physical symptoms.</p> <p>Concerns appear justified?</p> <p>NB: Genital findings that will confirm or exclude sexual abuse are uncommon and require expert interpretation. A child's disclosure to an expert interviewer is likely to be the most helpful investigation.</p> <p>Unsure if concerns justified?</p> <ul style="list-style-type: none"> Consider other causes for any symptoms or signs <p>Eg: UTI, glomerulonephritis, accidental injury.</p> <p>Concerns raised by yourself</p> <ul style="list-style-type: none"> Behavioural or physical symptoms <p>DISCUSS WITH LOCAL CHILD PROTECTION SERVICES OR PAEDIATRIC ASSESSMENT TEAM</p>	<p>Check safety</p> <p>Check for obvious medical problems eg pain/ bleeding or discharge?</p> <p>If history not particularly suggestive of sexual abuse then appropriate investigations to detect other causes and an external genital exam or genital swab may be indicated if it can be done without distressing the child. If unsure, discuss with local DSAC doctor or paediatric assessment service.</p>	<p>If no medical concerns refer to local child protective agency for investigation eg CYPS</p> <p>Liase with local services eg DSAC Doctor Child protective agency. DO NOT MAKE DECISIONS ON YOUR OWN</p> <p>Refer to paediatric assessment if medical indicators, to child protective agency for assessment or discuss with colleague trained in this area</p>
<p>ADOLESCENT SEXUAL ABUSE</p>	<p>If under fourteen years of age DSAC policy is to treat as child protocols above with mandatory reporting. Check your own services reporting policies</p> <p>If aged 14 years to 17 years and ability to keep themselves safe and no other children at risk then may choose to treat as per adult protocol However consider reporting all cases to either CYPS or Police. If considering not reporting a case, consult with experts working in this area before making that decision.</p>	<p>Key points</p> <ul style="list-style-type: none"> Neither adults nor children Confidentiality issues Safety issues Access to health care HEADSS assessment <p>[Note: Home, Education, Activities, Drugs, Sexuality and Suicide]</p> <p>Liase with local adolescent services if any doubts and never promise confidentiality incase of safety issues.</p> <ul style="list-style-type: none"> Complete ACC forms <p>If adamant no report to Police offer examination to reassure is ok and provide appropriate prophylaxis against pregnancy and STD as per DSAC protocols.</p>	<p>Refer all children under 14 to child protection agency and paediatric assessment service or Police</p> <p>Refer sexual health as may have specific services for adolescents</p> <p>OR</p> <p>If unsure about whether to report or how best to manage discuss with colleague with training in this area or local DSAC doctor</p>

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Diagnosis	Evaluation	Management Options	Referral Guidelines
ADULT SEXUAL ASSAULT MALE/ FEMALE	<p>Key points:</p> <ul style="list-style-type: none"> • Acute assault less than seven days • Genital / Genital contact • Do they wish to report to Police • Pain/ bleeding or discharge • Washed or showered or changed clothes • Are they safe 	<ul style="list-style-type: none"> • Preserve forensic evidence if only a few hours since assault ie. Avoid showers/ washing, keep clothing worn at time from being washed etc. • Assist report to Police if that is their wish • Assess urgent medical needs eg attend to injuries if necessary • If adamant no report to Police offer examination to reassure is ok and provide appropriate prophylaxis against pregnancy and STD as per DSAC protocols. • Offer crises counselling referral and provide ACC forms for time off work and to assist with counselling costs. 	<p>If wish to report phone Police and crises counselling service.</p> <p>If unsure re reporting then offer referral to crises counselling agency to assist with decision making process and provide crises counselling</p> <p>Refer local sexual health service who may have acute assessment team</p> <p>OR consult local DSAC doctor and discuss appropriate management.</p>
	<p>Non acute assault</p> <ul style="list-style-type: none"> • Do they wish to report to Police • Any pain bleeding or discharge • At risk of pregnancy 	<p>Offer crises counselling referral</p> <p>Offer medical to reassure all is O.K.</p> <p>ACC forms to assist with time off work and counselling if needed.</p>	<p>Refer Police if he/she wishes</p> <p>Refer crises counselling service and provide ACC forms to assist with costs</p> <p>Refer Sexual Health clinic for full STD assessment as prophylaxis too late</p>
Previously undisclosed sexual assault or survivors of Child sexual abuse	<p>Key Points</p> <ul style="list-style-type: none"> • Allow them to tell their story • Not our role to judge or assess if true or not • Ask them what they wish to do or how they think you can assist • Ask them how they feel the abuse/assault is still affecting them • Any concerns re pregnancy or infection or genital damage? • Evidence of profound psychological impairment? 	<ul style="list-style-type: none"> • Reassure them that their reactions and feelings are often seen in such situations • Offer medical to reassure 	<p>Refer to Counselling service if patient wishes to deal with any psychological sequelae.No time limitations.</p> <p>NB ensure counselling referral is to someone who is appropriately qualified and trained in this area. Local DSAC Doctor may be able to advise if you are unsure.</p> <p>May require psychiatric assistance</p> <p>May require full STD health check at Sexual health clinic</p>