

**Adult Bladder and Bowel Specialist Service**

ADULT Referral Form

### **Please print and complete all sections or it will be returned**

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| Referred By Date of Referral: Address / Ward/ DepartmentName:  Contact Telephone Number:  |
| Patients Details Title: Female/Male:Surname: Forenames: Address: Postcode: Telephone Number: Mobile Number:(Happy to receive text message communications Yes/No) Date of Birth:NHS number: | **GP Details**Name: Address: Telephone Number: |
| Carer / Next of Kin:Name: Relationship: Contact Address: Telephone Number:  |
| **Hospital Details:** Reason for admission /consultant – |
|  **Please give reason for referral:** **BLADDER** **BOWEL**  |
| **Has a referral been made to urology/gynaecology Y N****Medical History –** Medication – **Urinalysis****Excluded/Treated** Impaction UTI Retention  |
| **Other relevant information** i.e. Communication Difficulties / Disabilities / cognitive impairment**Is patient housebound Y N****Agency input** – Social Services District Nurse Other please state |
| **Signature Print Name Designation**This form must be signed by a Qualified Health Care professional |
| **NB Community Nurses / Ward Nurses please attach copy of Continence Care Pathway** **Primary assessments will be carried out by District Nurse** |
| **Send to:**Adult Bladder and Bowel Specialist Service Unit 8, The Forum, Coopers WayTemple Farm Industrial Estate, Southend on SeaSS2 5TE.Email: continence.referrals@nhs.net  | For Office Use |