Continence Advisory 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 Tel No.  |
| Patients Details Title Male / FemaleSurnameForenamesAddressPostcodeTel No  Date of BirthNHS no.  | **GP Details**NameAddressTel No. |
| Carer / Next of KinName Relationship Contact Address Tel No.  |
| **Hospital Details;** Reason for admission /consultant  |
| **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;**Willow WardRochford HospitalUnion Lane RochfordSS4 1RB Drop code 35FAX: 01702 372 002Email: continence.referrals@nhs.net  | For Office Use |

**FOR END OF LIFE PATIENTS ONLY PLEASE FAX REFERRAL TO 01702 538168**