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/ DepartmentNameContact Tel No. | | |
| Patients DetailsTitle Male / Female Surname  Forenames  Address  Postcode  Tel No    Date of Birth  NHS no. | | **GP Details**NameAddressTel No. |
| Carer / Next of KinNameRelationshipContact AddressTel 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 Ward  Rochford Hospital  Union Lane  Rochford  SS4 1RB Drop code 35  FAX: 01702 372 002  Email: continence.referrals@nhs.net | For Office Use | |

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