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| --- | --- |
| **COMMUNITY - SPECIALIST BLADDER & BOWEL SERVICE REFERRAL FORM****This form is to be used for both housebound & non-housebound patients**  |  |
| **Surname:** | Click here to enter text. | **First Name:** | Click here to enter text. |  |
| NHS No: |  Click here to enter text. | DOB: |  Click here to enter text. |  |
| Address / Post Code: |  Click here to enter text. | Ethnicity: |  Choose an item. |  |
| PT Phone No. |  Click here to enter text. |  |
| GP Name & Surgery: |  Click here to enter text. | Parent/ Carer/ Next of Kin | Click here to enter text. |  |
|  |
| **Presenting Bladder Symptoms: (please indicate all that apply)** |  |  |
| [ ]

|  |
| --- |
| Urgency and/or Frequency |

 | [ ]

|  |
| --- |
| Urge Incontinence  |

 | [ ]

|  |
| --- |
| Nocturia |

 | [ ] Stress Urinary

|  |
| --- |
| Incontinence |

 | [ ]

|  |
| --- |
| Pelvic Organ Prolapse |

 | [ ] Voiding Dysfunction |  |
| **Presenting Bowel Symptoms: (please indicate all that apply)** |  |  |
| [ ]

|  |
| --- |
| Urgency and/or |

Frequency | [ ]

|  |
| --- |
| Diarrhoea  |

 | [ ]

|  |
| --- |
| Constipation |

 | [ ]

|  |
| --- |
| Smearing |

 | [ ] Faecal

|  |
| --- |
| Incontinence |

 | [ ] Evacuation Difficulties |  |
| **History of presenting complaint:** Click here to enter text. |
| **Useful bladder & bowel links**: <https://www.nice.org.uk/guidance/cg171> NICE - Urinary Incontinence in Women<https://www.nice.org.uk/guidance/cG49> NICE - Faecal Incontinence<https://www.nice.org.uk/guidance/cg97> NICE - Lower Urinary Tract Symptoms in Men <https://www.nice.org.uk/guidance/cg61> NICE - Irritable Bowel Syndrome in Adults <https://pathways.nice.org.uk/pathways/constipation> NICE - Constipation in Adults Pathway **Please also refer to SE London APC formulary for local guidance**  |  |
|  |
|  |
|  |
| **Can patient attend clinic?** | YES [ ]  NO [ ]  | **Is an Interpreter required?** | YES [ ]  NO [ ]  |  |
| **Does patient require a home visit?** If yes, safety concerns **MUST** be completed below | YES [ ]  NO [ ]  | **If yes, specify language:** |  |
| **Significant medical history:** Please attach summary **Current Medication:** Please attach list |  |
|  |
| **Are there any safety concerns? i.e. pets, mental health (patient or family members), known drug use?** |  |
| **Name of Referrer:** |   |  |
| **Job Title /Designation:** |   |  |
| **Contact Number:** |  |  |
| **Date of Referral** |  Click here to enter a date. |  |
| **Please ensure you complete ALL aspects of the form and attach relevant information otherwise this referral may be rejected.**  |  |  |
| **LAMBETH & SOUTHWARK COMMUNITY SPECIALIST CONTINENCE SERVICE** |  |
| **Akerman H/C** |  |  |  |  |  |
| **60 Patmos Road** |  |  |  |  |  |
| **SW9 6AF** |  |  |  |  |  |  |
| ***t:* 0203 049 4020 *e:*** **gst-tr.dnreferrals@nhs.net** |  |  |  |
|  |  |  |  |  |  |  |