Continence and Urology Service

Referral Form (ADULTS INC CARE HOMES)

*(Post migration to INTS s1 unit version 31st Oct 22)*

Date of referral……………………………………….

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| PATIENT DETAILS  Name: D.O.B:NHS Number: | Address: Post Code: Tel. No: |
| REFERRED BY Name: Tel. No:Please tick below: - Care Home  Consultant  GP  Practice Nurse  Self-referral  Specialist Nurse  Urologist  Other (Please state) | |
| **FOR INFORMATION – the following requests should be directed to the Community Neighbourhood Nursing Service via the Single Point of Access, these will not be accepted by the Continence and Urology Service:**   * **Urgent catheterisation/patient in pain/not able to pass urine (Please phone the SPA on 01226 644575)** * **Female catheters** * **Nephrostomy Care** * **Ordering of catheter equipment** * **Bowel management (manual evacuation)** | |
| **INCLUSION CRITERIA**   * **Patients aged over 19 years +** * **Patients who have a Barnsley GP** * **Patients in a Barnsley area (we cannot deliver continence aids out of areas)**   **CARE HOME REFERRALS ONLY: *Please ensure all the below information is provided. Failure to do so may result in a delay in the referral being processed.***   * **24 hr Care Home Continence Referral completed** * **Bladder Frequency Volume Chart provided** * **Bowel Diary provided** * **Medication Sheets provided** | |
| **REASON FOR REFERRAL *(Please tick the primary reason for referral):***  **Bladder  Bowel Problems  End of life (pads)**  **Self-retaining Catheter  Intermittent Self-Catheterisation  Intermittent Self-Dilatation  TWOC**  **What is the patient experiencing? (General symptom description)**  **How is the patient managing currently? (Current management by patient – self-care)**  **Tick if patient using continence aids already**  **What are they using currently? (Type / Brand / Size):** | |
| **CLINIC/HOME VISIT**  **Tick if patient can come to clinic**  **Home visits only given to patients on GPs home visit list. Is this patient completely housebound?** | |
| **MEDICATION** | |