Continence and Urology Service

Referral Form (PAEDS 0-19yrs)

*Post migration to INTS s1 unit version Oct 22)*

Date of referral…………………………….

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| PATIENT DETAILS  Name: D.O.B:NHS Number: | Address: Post Code: Tel. No: |
| DETAILS OF PARENT/GUARDIAN  Name: | Relationship:  Tel. No. |
| REFERRED BY Name: Tel. No:Please tick below: - Paediatrician  Consultant  GP  Specialist Nurse  Ward  0-19 Services  Self-referral  Other please state: | |
| **EXCLUSION CRITERIA**  **Referrals received for patients with the following will be declined: -**   * **Continence products are not issued for containment of treatable conditions e.g., nocturnal enuresis (bed wetting) or faecal incontinence due to constipation. If toilet trained during the day but bedwetting at night these can be directed to School Nursing even if they have additional needs.**  Children under 4 years are not accepted by the service. Direct children under 4 years to the 0-19 Health Visiting Service on 01226 774411 | |
| **INCLUSION CRITERIA (*Please ensure all relevant information is ticked, failure to do so may result in a delay in the referral being processed)***   * **Must have a Statement of Educational Needs/Educational Health and Care Plan** * **Must be under the care of a Consultant Paediatrician** * **Must have continence problems due to having a physical or learning disability that affects ability to become continent** | |
| **REASON FOR REFERRAL *(Please tick the primary reason for referral):***  **Bladder (toilet training needed)  Bowel (toilet training needed)**  **What is the patient experiencing? (General symptom description)**  **How is the patient managing currently? (Current management / self-care)**  **Tick if patient is using continence aids already**  **What continence aids are they using currently (Type, Model, Size):**  **Is the child using nappies  or pull ups** | |
| **MEDICATION** | |
| **PAST MEDICAL HISTORY / DISABILITIES / MOBILITY** | |