

**Adult Bladder and Bowel Specialist 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 Telephone Number: | | |
| Patients DetailsTitle:Female/Male: Surname:  Forenames:  Address:  Postcode:  Telephone Number:  Mobile Number:  (Happy to receive text message communications  Yes/No)  Date of Birth:  NHS number: | | **GP Details**Name:Address:Telephone Number: |
| Carer / Next of Kin:Name:Relationship:Contact Address:Telephone Number: |
| **Hospital Details:** Reason for admission /consultant – | | |
| **Please give 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:**  Adult Bladder and Bowel Specialist Service  Unit 8, The Forum, Coopers Way  Temple Farm Industrial Estate, Southend on Sea  SS2 5TE.  Email: [continence.referrals@nhs.net](mailto:continence.referrals@nhs.net) | For Office Use | |