|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **COMMUNITY SPECIALIST BLADDER & BOWEL SERVICE REFERRAL FORM** | | | | | | |  |
| **Surname:** |  | | | **First Name:** |  | |  |
| NHS No: |  | | | DOB: |  | |  |
| Address / Post Code: |  | | | Ethnicity: |  | |  |
| PT Phone No. |  | |  |
| GP Name & Surgery: |  | | | Parent/ Carer/ Advocate/ Next of Kin |  | |  |
|  |
| **Presenting Bladder Symptoms: (please indicate all that apply)** | | | | | |  |  |
| |  | | --- | | Urgency | | |  | | --- | | Frequency | | | |  | | --- | | Urge | | |  | | --- | | Nocturia | | |  | | --- | | Incontinence | |  |  |
|  |  | |  |  |  |  |  |
| **Presenting Bowel Symptoms: (please indicate all that apply)** | | | | | |  |  |
| |  | | --- | | Urgency | | |  | | --- | | Frequency | | | |  | | --- | | Constipation | | |  | | --- | | Smearing | | |  | | --- | | Incontinence | |  |  |
|  |  | |  |  |  |  |  |
| **REASON FOR REFERRAL** | | |  |  |  |  |  |
|  | | | | | | |  |
|  |
|  |
|  |
| Can patient attend clinic? | | | YES / NO | Patient requires a home visit? | | YES / NO |  |
| Is an Interpreter required? | | | YES / NO | If yes, specify language: | | |  |
|  |  | |  |  |  |  |  |
| If patient is currently in hospital, what is the anticipated discharge date? | | | | | | |  |
|  |  | |  |  |  |  |  |
| Current Medication: (attach list if possible) | | | | | | |  |
|  |
|  |  | |  |  |  |  |  |
| Are there any Safeguarding issues? | | | | | | |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
| **Name of Referrer:** | |  | | | | |  |
| **Job Title /Designation:** | |  | | | | |  |
| **Contact Number:** | |  | | | | |  |
| **Date of Referral** | |  | | | | |  |
|  |  |  | |  |  |  |  |
| **PLEASE EMAIL,:** | | | | | |  |  |
|  |  | |  |  |  |  |  |
| **LAMBETH & SOUTHWARK COMMUNITY SPECIALIST CONTINENCE SERVICE** | | | | | | |  |
| **Akerman H/C** | | |  |  |  |  |  |
| **60 Patmos Road** | | |  |  |  |  |  |
| **London** |  | |  |  |  |  |  |
| **SW9 6AF** |  | |  |  |  |  |  |
|  |  | |  |  |  |  |  |
| **PHONE: 0203 049 4020** | | |  |  |  |  |  |
|  | | |  |  |  |  |  |
| **EMAIL** [**Gst-tr.dnreferrals@nhs.net**](mailto:Gst-tr.dnreferrals@nhs.net) | | | | |  |  |  |
|  |  | |  |  |  |  |  |