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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** | | | | | | | |  |
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|  |
| **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**](mailto:gst-tr.dnreferrals@nhs.net) | | | | |  |  | |  |
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