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| **Referrer information** |
| Referring clinician | Click here to enter text. | Referral date | Click here to enter a date. |
| Department and Organisation | Click here to enter text. | Referrer contact Number | Click here to enter text. |
| Address | Click here to enter text. | Referrer email address (please ensure a secure email address) | Click here to enter text. |

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| **GP Practice Information** |
| GP Details: | Click here to enter text. | Address: | Click here to enter text. |

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| **Patient Details** |
| Surname: Click here to enter text.  | Forename: Click here to enter text.  | Title: Mr.[ ]  Mrs.[ ]  Ms[ ]  Miss[ ]  Other : Click here to enter text. |
| Date of Birth: Click here to enter text. | NHS No. Click here to enter text. | Phone number: Click here to enter text. |
| What is the patient’s preferred first language? Click here to enter text. | Address : Click here to enter text. |
| Does the patient have any special communication needs or language barriers? [ ]  Y [ ]  N Click here to enter text. |

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| **Urinary Symptoms: Not applicable** [ ]  |
| [ ]  Y [ ]  N Frequency  | [ ]  Y [ ]  N Stress incontinence  | [ ]  Y [ ]  N Nocturia (night-time frequency)  |
| [ ]  Y [ ]  N Urgency  | [ ]  Y [ ]  N Urge Incontinence  | [ ]  Y [ ]  N Feeling incomplete emptying  |
| [ ]  Y [ ]  N Passive leakage  | [ ]  Y [ ]  N Unable to get to toilet due to mobility | [ ]  Y [ ]  N Cognitive problems |
| Others, please state: Click here to enter text. |

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| **Bowel Symptoms:** Not applicable [ ]  |
| [ ]  Y [ ]  N Constipation  | [ ]  Y [ ]  N Diarrhoea  | [ ]  Y [ ]  N  Smearing | [ ]  Y [ ]  N Faecal Incontinence | [ ]  Y [ ]  N EvacuationDifficulties  | [ ]  Y [ ]  N Urgency and/or Frequency |
| Others please state: Click here to enter text. |

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| NOTES:1. *Symptoms/ Bladder/Bowel History*
2. *Please note: If the patient is unable to attend a clinic or get up onto an examination couch, the referral should be made to the appropriate community nursing team.*
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**Safeguarding, adaptations or factors of concern: *are there any safeguarding concerns (eg neglect, abuse), needs for reasonable adjustments including those with LD, autism and characteristics as defined by the Mental Health******Act 1983***

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| Provisional Diagnosis and Examination Findings (including any red flags), investigations, results:*e.g Urinalysis Results* |

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| Staff Safety – Are there any issues that we should be aware of which staff should be aware: - YES/NOIf yes, please give details of infection risk, patient or family history:  |

Please note: If the patient is unable to attend a clinic the referral should be made to the appropriate community nursing team.

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| **You can check on the progress of your referral by** 1. **Logging on to EMIS Web, using your smartcard.**
2. **Press F5 or click the Patient Find icon to select the required patient.**

**The Summary screen is displayed on the left hand side of the page.If required, click chevron right at the left-hand side of the screen to expand the shared records pane. Select the required organisation from the External Views section.The selected patient must be actively registered at a TPP organisation that you have a direct sharing agreement with, to be available for selection from the External Views.** |

By submitting this form, I confirm that there is a legitimate/lawful basis to the disclosure of the information contained on the form for the purpose of direct care and consent has been given or is strongly implied.