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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  Evacuation Difficulties | 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.* |

**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/NO  If 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.