**PaediatricBladder and Bowel Service**

**Referral Form**

**Please ensure all sections of this form are completed and email to** **childrenscontinence@stockport.nhs.uk**

**Please note: if this form is not fully completed, we will be unable to accept the referral.**

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| **BLADDER AND BOWEL ASSESSMENT** **Please ensure level 1 assessment is completed and documented prior to referral. If this is not completed and documented, we will be unable to accept the referral.**  |
| **1st** | Date of 1st assessment related to bladder/bowel complaint: |       |
| Summary of 1st assessment including presenting complaint, investigations, and recommendations: |       |
| **2nd** | Date of re-assessment: |       |
| Reason for referral to Level 2 Paediatric Bladder and Bowel Specialist service: *(Please provide details and complete assessment below)* |       |
| **Bowel assessment** |
| How often is the child opening their bowels? |
| Type of stools: Soft/hard/loose stools?  |
| Where? Nappy [ ]  Pants [ ]  Toilet [ ]   | Is soiling an issue? Day [ ]  Night [ ]   |
| Prior to referral, please ensure all children and young people with symptoms of constipation have had a physical examination completed to rule out any red flag symptoms and possible underlying causes (NICE CG99). |
| **Bladder assessment** |
| Is the child wetting during the day? Yes [ ]  No [ ]   | Damp/wet/soaking?       |
| Do they have urgency? Yes [ ]  No [ ]   | Do they have frequency? Yes [ ]  No [ ]   |
| Is the child wet at night? Yes [ ]  No [ ]   | How many wet nights per week?  |
| Fluid intake per 24 hours: |  |
| Please ensure all children and young people with wetting symptoms have a urine dipstick (NICE, CG111) |

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| **PATIENT DETAILS** |
| Child’s Name: |       | M/F | Mother’s Name |       |
| DOB: |       | Age  |       | Mother’s Tel No. |       |
| Address: |       | Mother’s Address |       |
| Tel No. (Home): |       | Father’s Name |       |
| Tel No. (Mobile): |       | Father’s Tel No. |       |
| NHS No: |       | Father’s Address |       |
| Religion: |       |
| Ethnicity: |       |
| Name & Address of School/Nursery: |       | Parental responsibility: | Mum [ ]  Dad [ ]  Both [ ] Other (specify):        |
| Name of Referrer and Designation: |       |
| Address of Referrer: |       |

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| **GP DETAILS** |
| Named GP: |       |
| GP surgery & address: |       |
| Is the patient known to any other agencies?E.g., Paediatrician, CAMHS, Audiology etc. | Yes [ ]  No [ ] If yes, please give details:       |
| Has the patient been referred to a Consultant Paediatrician for this problem? | Yes [ ]  No [ ] If yes, please give date:       |
| **CLINICAL EXAMINATION** (Please include date and results of urinalysis and physical examination)      |
| **BACKGROUND INFORMATION** (birth history, development milestones, developmental concerns etc)      |
| **MEDICAL/SURGICAL HISTORY**      |
| **FAMILY HISTORY OF BOWEL OR BLADDER PROBLEMS**      |
| **CURRENT MEDICATION**      |
| **ALLERGIES**      |

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| **SAFEGUARDING** |
| Is there a Child Protection plan? | Yes [ ]  No [ ]  |
| Is there a Child in Need plan? | Yes [ ]  No [ ]  |
| Is there an Early Help Plan? | Yes [ ]  No [ ]  |
| Lead Professional Name, Role & Contact Details: |        |
| Are there any other safeguarding concerns that we need to be aware of? | Yes [ ]  No [ ] If Yes, please give details:       |

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| **COMMUNICATION & ACCESSIBILITY** |
| Interpreter required? | Yes [ ]  No [ ]  If yes, which language?       |
| Any communication difficulties? | Yes [ ]  No [ ]  Details: |
| Does the patient have any physical/learning disabilities? | Yes [ ]  No [ ]  Details: |
| Are there any known risks related to visiting the patient at home?(e.g. dogs, environmental risk, any known aggressive behaviour or Health & Safety Issues) | Yes [ ]  No [ ]  If yes, please describe:       |