**PaediatricBladder and Bowel Service**

**Referral Form**

**Please ensure all sections of this form are completed and email to** [**childrenscontinence@stockport.nhs.uk**](mailto: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: |