

**Community Urology and Bowel Health Referral Form**

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| **Date:** | **Time:** |
| **Name:** | **DOB:** |
| **Address:**  **Postcode:** | **GP:**  **Surgery:** |
| **Telephone:** | **Telephone:** |
| **Referrer:** | **NHS Number:** |
| **Reason for Referral:**  **Routine:** | **High Risk:**  **Bedbound □**  **Pressure Sores □**  **CVA within 12 Months □**  **CA Bladder □**  **CA Bowel □**  **Surgery within 6 Months □** |
| **Symptoms:** |  |
| **PLEASE NOTE: IF PATIENTS PRESENT WITH ANY OF THE FOLLOWING, THEY MUST BE REFERRED TO SECONDARY CARE:**  **Urgently refer:**   * Microscope haematuria if aged 50 years and older * Visible haematuria * Recurrent or persisting UTI * Suspected pelvic mass arising from urinary tract   **Refer with:**   * Symptomatic prolapse visible at or below the vaginal introitus * Residual urine > 200mls with deranged U+E’s   **Is there any blood in their urine/stools?**  **□ Yes □ No** | **Consider referring with:**   * Persisting bladder or urethral pain * Clinically benign pelvic masses * Associated faecal incontinence * Suspected neurological disease * Voiding difficulty, e.g. hesitancy, reduced flow rate, nocturia * Suspected urogenital fistula * Previous pelvic cancer surgery * Previous pelvic radiation therapy   **(NICE Guidelines Oct 2006)**  **Do they have persistent pain in their bladder?**  **□ Yes □ No** |
| **If yes to the above:**  **Have they seen their GP?**  **□ Yes □ No** | **Have they had any treatment for the problem in the past?**  **□ Yes □ No** |
| **Past Medical History:**  **□ Neurological Disorder □ Dementia □ COPD**  **□ Diabetic □ Prostate Problems**  **Other …………………………………………………………………………………………………………………….** | |
| **Have they ever had any surgery to their:**  **□ Prostate □ Bladder □ Bowel**    **If so, how long ago? …………………………………………………………………………………………………...** | |
| **Have they ever been seen by:**  **□ Urology □ Physiotherapy □ CUBHS**  **If so, how long ago? …………………………………………………………………………………………………...** | |
| **Medication:** | |
| **How do they currently manage the problem?** | |
| **Are they currently receiving products on the Home Delivery Service? □ Yes □ No**  **If so, what products are they receiving? ………………………………………………………………………….** | |
| **Are they housebound? □ Yes □ No** | **Are they able to get to clinic? □ Yes □ No** |
| **Signature:** | |