**Community Urology and Bowel Health Referral Form**

|  |  |
| --- | --- |
| **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:** |