**EXCLUSION CRITERIA**

* District Nursing involvement, refer to District Nurse for assessment
* Red flags; refer to secondary care:

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| **Red Flags MALES - for immediate referral to**  **Urology secondary care service via GP**   * Haematuria * Elevated PSA * Palpable bladder * Suspected mass | **Red flags FEMALES - for immediate referral to**  **secondary care via GP**   * Micro haematuria 50+ years * Recurrent UTI with haematuria 40+ years * Suspected mass * Severe prolapse * Visible haematuria |

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| For any queries, please telephone the **CCICP Continence Service** on **01270 275411** (Mon-Fri 9:00-17:00)  **Please ensure this form is fully completed and attach any relevant additional information**  **and e-mail to** [**tmc-tr.communitycontinenceteam@nhs.net**](mailto:tmc-tr.communitycontinenceteam@nhs.net) |

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| **PATIENT DETAILS** | | | | **GP DETAILS** | |
| **Name** | Title | Given Name | Surname | **GP Name** | Usual GP Full Name |
| **DOB** | Date of Birth | | | **GP GMC No.** | Usual GP GMC Number |
| **Address** | Home Full Address (single line) | | | **Name of Referrer** |  |
| **Tel No** | Home: Patient Home Telephone  Mobile: Patient Mobile Telephone | | | **Surgery** | Organisation Name  Organisation Full Address (single line) |
| **NHS No.** | NHS Number | | | **Practice code** | Organisation National Practice Code |
| **Email Address** | Patient E-mail Address | | | **Tel** | Organisation Telephone Number |
| **Ethnicity** | Ethnic Origin | | | **Fax** | Organisation Fax Number |
| **Religion** | Religion | | | **Referral date** | Short date letter merged |
| **Next of Kin** |  | | |  |  |
| **Interpreter required?** | Yes  No  If Yes, which language? | | |  |  |

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| **PATIENT ACCESS** | | | |
| Aware of any **risks** that should be considered prior to visiting the patient?  (e.g. VRSA, MRSA, dogs, environmental risk, any known aggressive behaviour or Health & Safety Issues)  If Yes, please describe: | | Yes | No |
| Does the patient **live alone**?YesNo | Is the patient **housebound**? Yes  No | | |

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| **REASON FOR REFERRAL** *(presenting urinary/bowel symptoms)* |
| **PHYSICAL EXAMINATION**  *(i.e. abdominal/bi-manual examination/prolapse assessment/rectal/blood PSA level/urinalysis/MSSU/CSU)* |
| **RELEVANT MEDICAL / SURGICAL HISTORY** |

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| **HEALTH PROFILE** |

Height

Weight

BMI

|  |
| --- |
| **Last 5 BPs** |

Blood Pressure

Family History

Allergies

Single Code Entry: H/O: non-drug allergy

Problems

Medication

Values and Investigations

Radiology