**REFERRAL CRITERIA**

* Children and young people aged 5-18 years (in full time education) with bladder and/or bowel dysfunction
* Children of pre-school age who have undergone 3 months of formal toilet training and have Special Educational Needs (SEN) and have an Education Health & Care Plan (EHCP) in place

If this is a referral for continence products please note the child must meet the above criteria and an appropriate bladder and bowel assessment must have been completed, this can be done by Health Visitor or School Nursing Team. If you feel the child/young person does not meet the above criteria but may still warrant a referral or you need further advice please contact the Paediatric Continence Advisors on **01270 275411** (Mon-Fri 9:00-17:00).

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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)* |
| **CLINICAL EXAMINATION** *(i.e. medical history, including Urinalysis result and date)* |
| **BACKGROUND INFORMATION** *(birth history, development milestones, etc)* |

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| --- | --- |
| Is there a Child Protection/Child in Need Plan or **CAF/TAF in place**? | Yes  No |
| **Lead Professional & Contact Details** |  |
| Are there any other **safeguarding issues** that we need to be aware of? | Yes  No  If Yes, please give details: |
| Has the patient been **referred to a Consultant** for this problem? | Yes  No  If Yes, please give date: |
| Is the patient **known to any other agencies**, for example Paediatricians, Audiology etc. | Yes  No  If Yes, please give details: |

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| **HEALTH PROFILE PLEASE ANSWER THOSE APPLICABLE** |

* Height
* Weight

* BMI
* Blood Pressure

* Medication Taken or to be commenced
* Family History

* Allergies

* Single Code Entry: H/O: non-drug allergy
* Labatory Values and Investigations

* Radiology

Referred by (Signature):

Date:

Name (print):

Profession:

Base:

The completed form should be emailed to The Continence Advisory Service @

**tmc-tr.communitycontinenceteam@nhs.net**