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| **Bladder and Bowel Service Referral Form**  **To be completed by a Health Care Professional** |

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| **If patient reports any abnormal bleeding or red flag symptoms - please advise patient to see GP** |

Send to: [mft.bladderbowelteam@nhs.net](mailto:mft.bladderbowelteam@nhs.net) from nhs.net email account or

[SouthBladder.BowelTeam@mft.nhs.uk](mailto:SouthBladder.BowelTeam@mft.nhs.uk) from MFT email account

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| **Patient name** |  | **GP name** | |  |
| **Patient address and postcode** |  | **GP address** | |  |
| **Date of birth** |  | **GP telephone number** | |  |
| **NHS number** |  | **Referrer name and contact details** | |  |
| **Telephone number** |  |
|  | | | | |
| **Has consent been obtained from patient, family and/or carers for this referral** Please circle Yes / No | | | | |
|  | | |  | |
| **Given birth in last year** Please circle Yes / No | | | **Palliative** Please circle Yes / No | |

**Presenting Symptoms (please tick)**

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| **Stress urinary incontinence-** symptoms of involuntary urine leakage on effort, exertion, sneezing or coughing |  | **Voiding dysfunction-** symptoms of slow or intermittent stream, terminal dribble, incomplete/difficult emptying the bladder or post micturition dribble |  | **Bowel dysfunction-** Symptoms of involuntary or inappropriate passage of faeces or constipation **seek medical advice if blood in stools** |  |
| **Overactive bladder-**symptoms or urinary urgency, usually with urgency frequency and nocturia, with or without urinary incontinence |  | **Functional incontinence-** Symptoms of urinary or faecal incontinence related to chronic impairment of cognitive function and/or practical issues that interfere with independent toileting skills i.e. poor mobility/dexterity |  |

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| Does the patient require any communication, translation or interpretation support? Please specify | | | | | | | | | | |
| Are there any Health and Safety issues for patient / staff?  Please circle Yes / No  Details: | | | | | | | | | | |
| Does the patient have any memory loss?  Please circle Yes / No  Details: | | | | | | | | | | |
| Does the patient have any disabilities that would make attending a clinic appointment difficult for them?  Please circle Yes / No  Details: | | | | | | | | | | |
| Current management?  Pads Sheath Indwelling catheter intermittent catheter other | | | | | | | | | | |
| Health Care Professional to complete where possible – do not perform if catheter insitu | | | | | | | | | | |
|  | Date | Glucose | Ketones | SG | Blood | pH | Protein | Nitrites | Leucocytes | MSU/CSU sent |
| \*Initial Urinalysis |  |  |  |  |  |  |  |  |  | Y / N |

*\* Please discuss with Bladder & Bowel team or GP if abnormal*

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| **MEN ONLY - Has the patient had a DRE performed?** Please circle Yes / No  **Date performed Result** |
| **MEN ONLY - Has the patient had PSA investigation?** Please circle Yes / No  **Date performed Result** ng/mL |

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| **Print Name** | **Signature** |
| **Designation** | **Date** |

If you require any further information about the service we provide or would like to discuss this referral please contact the Bladder & Bowel Service: 0161 549 6642 Monday to Friday 8:30am – 4:30pm