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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 from nhs.net email account or

 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** |  |
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| **Has consent been obtained from patient, family and/or carers for this referral** Please circle Yes / No |
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| **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 / NoDetails: |
| Does the patient have any memory loss? Please circle Yes / NoDetails: |
| Does the patient have any disabilities that would make attending a clinic appointment difficult for them?Please circle Yes / NoDetails: |
| 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