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| **Bladder and Bowel Service Referral Form**  **Self or Patient Advocate Referral Form** |

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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:** |  |
| **GP telephone number** |  |
| **Date of birth:** |  | **Referrer Name** |  |
| **NHS Number:** |  | **Relationship to patient:** |  |
| **Telephone number:** |  | **Contact number:** |  |

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| **Has consent been given by patient for this referral?** Please circle Yes / No / NA |

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| **Given birth in last year?** Please circle Yes / No | **Palliative?** Please circle Yes / No |
| **Presenting bladder and/or bowel problems** | |
| **Summary:** | |

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| **Consent obtained to source medical history from GP:** Yes / No |
| **Do you or the patient require any communication, translation or interpretation support?** Please specify |
| **Do you/or the patient have any memory deficit?**  Please circle Yes / No  **Details:** |
| **Do you or the patient have any disabilities that would make attending a clinic appointment a problem for them?**  Please circle Yes / No  **Details:** |

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| **For Men Only** | |
| **Have you or the patient had a DRE performed?**  Please circle Yes / No  **Date performed:** | **Have you or the patient had a PSA investigation?**  **Latest date performed:**  **Result**: ng/mL |
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| **Where did you hear about our service? Details:** | |

**Any other comments:**