

CONTINENCE SERVICE REFERRAL

Patients Details Referral Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | NHS No |  |
| Forename |  | Surname |  |
| Address |  | | |
| Postcode |  | DOB |  |
| Telephone |  | Mobile |  |
| Ethnicity |  | Interpreter/signer Required | Yes/No  If yes male/female |
| Previous Medical History | Please complete/attach | | |
| Medication List | Please complete/attach | | |
| GP Name |  | | |
| GP Addres |  | | |
| GP Telephone |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Known Lone Worker Risk | Yes/No  If yes please specify | | | Other risk/alert- please specify | |
| Does GP visit Patient at home | Yes | | No | | |
| Has patient consented to referral | Yes/No  If No-unable to proceed without consent unless lacks capacity | | Lacks capacity-how was capacity established? | | |
| Is patient involved with community nursing team Yes/No  **If yes- community nursing to undertake level 1 continence assessment** | | Other Community services involved Yes/No  If yes specify- | | | |
| Does patient live alone  Yes/No | If No- household composition | If Yes-Access to property (eg key code) | | | If Yes-Contact telephone no for Next of kin- |

REASON FOR REFERRAL

|  |
| --- |
| main problems  symptoms |

Referrer Details

|  |  |
| --- | --- |
| Referral Date |  |
| Referrer Name |  |
| Designation |  |
| Referrer Address |  |
| Telephone |  |

**Please fax or post referral to:**

|  |  |
| --- | --- |
| Cumbria Continence Service (North)  London Road Community Clinic, Hilltop Heights, Carlisle CA1 2NS | Telephone: 01228 608060  Fax: 01228 546206 |

Continence Office Administration

|  |  |  |  |
| --- | --- | --- | --- |
| Date Received |  | Triaged by |  |
| Received by |  | Triaged to | AP/SpN |
| Known to Abena | Yes/No | Date Triaged |  |
| Clinic type | HV/Clinic |  | |
| Additional information | | | |