



Children's Continence Service
Referral Form

+Surname:		Date of Birth: <small>(format: dd/mm/yyyy)</small>	
Forename(s):		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Post Code:	
		NHS No:	
Home Tel No:		Mobile No:	
Mother's Contact No:		Father's Contact No:	

Registered GP		Surgery	
Practice Code	J		
Consultant <small>(if appropriate)</small>			

Ethnicity:		Interpreter Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Reason for referral <i>(Please attach previous management tried)</i>

Relevant medical/social history/learning difficulties/safeguarding concerns

Medication:					
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Is parent/guardian aware of referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Is GP aware of referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Are there any other professional/agencies involved with the family? <small>(please tick appropriate box/boxes)</small>	Health Visitor <input type="checkbox"/>	CAMHS <input type="checkbox"/>	Known to Social Services <input type="checkbox"/>
	Other None <input type="checkbox"/>	Paediatrician <small>(please specify)</small>	

School:		School Nurse:	
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Referral raised by:		Date: <small>(format: dd/mm/yyyy)</small>	
Signature:		Designation:	
Address:	Post Code:	Telephone No:	
		Mobile No:	



Surname:		Date of Birth: <small>(format: dd/mm/yyyy)</small>		NHS No	
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Additional information, please tick or complete where appropriate

Day wetting		Night Wetting	
Number of wet days a week		Number of wet nights a week	
Number of wet episodes a day		Number of wet episodes a night	
Amount of wetness		Wakes to void/wetness	
Frequency/Urgency		Nappies/pull-ups	
UTI's		Medication	
Medication		Alarm	

Frequency of Defecation (please tick)		Soiling	
Daily	<input type="checkbox"/>	Medication: Senokot <input type="checkbox"/> Lactulose <input type="checkbox"/> Movicol <input type="checkbox"/>	
Alternate days	<input type="checkbox"/>	How much?	
Twice per week	<input type="checkbox"/>	Any soiling? Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/>	
Less often	<input type="checkbox"/>	How often? > Once a day <input type="checkbox"/> > Twice a day <input type="checkbox"/>	
Is there pain on defecation	Yes <input type="checkbox"/> No <input type="checkbox"/>	How much? Full poo <input type="checkbox"/> Large poo <input type="checkbox"/> Smears <input type="checkbox"/>	
Description of stool: Firm <input type="checkbox"/> Soft <input type="checkbox"/> Loose <input type="checkbox"/>		Is it a Formed stool <input type="checkbox"/> Loose stool <input type="checkbox"/>	

Strategies tried in the past:

Are there any other professionals/agencies involved in with the family?

Is the family known to Social Services or cause for concern?

Relevant medical/social history: ie Learning Difficulties/at risk etc