



Children's Continence Service Referral Form

Referral criteria

Any child aged between 4 and 19 years with	<ul style="list-style-type: none"> • Daytime Wetting • Daytime frequency and / or urgency • Wetting with urinary tract infections
Any child aged between 5 – 19 years with	<ul style="list-style-type: none"> • Night time wetting • Night wetting with family history of renal disease.
Any child aged between 2 – 19 years with	<ul style="list-style-type: none"> • Constipation and soiling. Stool holding.
Consider referral and discuss with the Children's Continence Team Children whom you are working with who have:	<ul style="list-style-type: none"> • Worsening Symptoms • Poor Progress/no progress over six months • Other complicating factors

Surname:		Date of Birth:	
Forename(s):		Gender:	
Address:		Post Code:	
		NHS No:	
Home Tel No:		Mobile No:	
Mother's Contact No:		Father's Contact No:	

Registered GP		Surgery	
Practice Code			
Consultant (if appropriate)			

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? (please tick appropriate box/boxes)	Health Visitor <input type="checkbox"/>	CAMHS <input type="checkbox"/>	Known to Social Services <input type="checkbox"/>
	Other <input type="checkbox"/>	None <input type="checkbox"/>	
	Paediatrician (please specify)		

School:		School Nurse:	
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Referral raised by:		Date:	31/01/18
Signature:		Designation:	

Address:		Organisation:	
		Telephone No:	

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"/> Laxido <input type="checkbox"/> Movicol <input type="checkbox"/>	
Alternate days	<input type="checkbox"/>	How much? Unsure	
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"/> Variable <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:

ERIC Bowel information shared

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

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

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

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Sharing In

Does the patient consent to the viewing of data by Solent Community Hospital that is recorded at other care services that may care for the patient where the patient has agreed to make the data shareable?

- Consent Given
 Consent Refused
 Consent not asked

***This box must be completed**

If Using SystmOne: Please send this form via electronic referral, selecting the following task recipient

1 Paed Continence eReferral

If Not Using SystmOne: Please send this form to:

snhs.childrenscontinence@nhs.net

For Further Advice, Please Contact Us On: Tel No: 0300 123 3797

Children's Continence Service, 2nd Floor, Adelaide Health Centre, William Macleod Way, Southampton, SO16 4XE