Cumbria Partnership NHS
NHS Foundation Trust

COMMUNITY BLADDER AND BOWEL SERVICE REFERRAL FORM

ALL SECTIONS NEED TO BE FILLED IN OR THE REFERRAL WILL BE DECLINED AND RETURNED. THIS WILL DELAY TREATMENT.

Prior to referral please ensure red flag symptoms are investigated/ referred back to GP.

- **Unexplained weight loss**
- **Change in bladder or bowel habit**
- **Haematuria / repeated UTI / Pain**
- **Palpable masses/ abdo rectal / vaginal**

Is the patient known to the District / Learning Disabilities Nurses? Yes / No
(If yes please ask them to complete the Continence Assessment).

Referral to the Community Bladder and Bowel Service is for assessment and treatment of symptoms.

Only if treatment is NOT successful will padded products be assessed for utilising the CPFT Policy and Continence Assessment Score Tool. Patients purchasing own products is NOT a symptom.

Exception to the above is END OF LIFE CARE under AMBER/RED on the End of Life Care traffic light system.

Patient Details:

Surname:	Forename:	Title: Mr. Mrs. Ms Miss Do they identify with the sex they were at birth? Yes No
Date of Birth:	NHS No.	Home Tel:
Mobile:	Work Tel.	Email:
Name and telephone number for next of kin or other contact details eg Access code:		
Address including Post Code: Do they want an SMS text reminder? Yes No		
GP Name/Address and Telephone number		

Please email completed referral forms to Continence.TeamNorth@cumbria.nhs.uk

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Urinary Symptoms: Not applicable ☐

☐Y ☐N Frequency	☐Y ☐N Stress incontinence	☐Y ☐N Nocturia
☐Y ☐N Urgency	☐Y ☐N Urge Incontinence	☐Y ☐N Feeling incomplete emptying
☐Y ☐N Poor stream	☐Y ☐N Hesitancy	☐Y ☐N Post Micturition Dribble
☐Y ☐N Unaware of sensation	☐Y ☐N Unable to get to toilet	☐Y ☐N Behaviour problem
Others, please state:		

Bowel Symptoms: Not applicable ☐

☐Y ☐N Constipation	☐Y ☐N Soiling / Lack of control	☐Y ☐N Diarrhoea
☐Y ☐N Unaware of sensation	☐Y ☐N Unable to control wind / flatus	☐Y ☐N Unable to empty bowel fully
☐Y ☐N Unable to get to toilet	☐Y ☐N Behaviour problem	
Others please state:		

Obstetric History: Not applicable ☐

☐Y ☐N Given Birth in last year	Number of Births :
Caesarean Sections :	Instrumental deliveries :
Others, please state:	

Prostate History: **Not applicable** ☐

History of prostate problems? If yes please state

Has the prostate been checked? Y / N Last PSA result / date:

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Other Relevant History:

Medical History – Please state or attach
Surgical History – Please state or attach
Current Medication – Please state or attach
If treated by a Gynaecologist, please state or attach:
If treated by a Urologist / Gastroenterologist, please state or attach:
Has the patient received treatment for the same condition before ☐Y ☐N Comments:

Has Consent been given by the patient to this referral? ☐Y ☐N **if NO – unable to proceed without consent unless lacks capacity** Lacks capacity- how was capacity established? Known loan worker risk? ☐Y ☐N Any other risks?(Dogs etc for home visits) ☐Y ☐N Comments:
Can the patient mobilise? Y / N If NO please state what equipment is utilised and if assistance is required to use this:- Is Disabled Access required? ☐Y ☐N
Is the patient able to go shopping, attend hair appointment etc? Yes / No (If No see below) Is the patient housebound and does not leave the home? Yes / No

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What is the patient's ETHNICITY and preferred first language?
If the patient requires any communication, translation or interpretation support, i.e. any hearing or visual impairments requiring specialist help (sign language, Braille, loop induction system), please specify:

Referrer Details:

Name:	Role / Relation:
Tel: Mobile No.	Email:
Signature :	Date:

Triage Details:

Date	Allocated to	Clinic/HV	Rejected and reason	Triage nurse initials