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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **URINARY CONTINENCE REFERRAL FORM FOR MEN AND WOMEN** | | | | | | | | | | |
| **Accurate completion of this form will ensure that patients are triaged correctly.** | | | | | | | | | | **TICK ONE** |
| **CLINIC APPOINTMENT** – patients may be seen by the Specialist Continence Service or Specialist Men’s and Women’s Physiotherapy Department. | | | | | | | | | |  |
| **HOME VISIT** – **ONLY FOR HOUSEBOUND PATIENTS**, i.e. are not able to attend their GP practice for appointments. Patient will be visited by the Community Care Teams (CCT) | | | | | | | | | |  |
| **Exclude or refer to Secondary Care: Adapted from NICE guideline [NG123)**  **Gynaecology:**  Urgently refer women (for an appointment within 2 weeks) with:   * Suspected pelvic mass   Refer women with:   * Symptomatic prolapse visible at or below the vaginal introitus * Symptomatic fibroid * Suspected urogenital fistulae   **Urology:**  Refer using a **suspected cancer pathway referral** (for an appointment within 2 weeks) for bladder cancer if they are:   * aged 45 and over and have unexplained visible haematuria without urinary tract infection **or** * visible haematuria that persists or recurs 2 weeks after successful treatment of urinary tract infection, **or** * aged 60 and over and have unexplained non‑visible haematuria   Refer if:   * Palpable bladder on bimanual or physical examination after voiding * Persisting bladder or urethral pain   Consider **non-urgent** referral if:   * Age <60 years with unexplained non-visible haematuria associated with urinary tract symptoms (e.g. loin pain, LUTS). * Recurrent or persistent unexplained UTI. * Age <45 years with unexplained visible haematuria. * For patients <60 years with asymptomatic non-visible haematuria, a renal USS should be considered. | | | | | | | | | | |
| **Patient Details** | | | | | | | | | | |
| **Name:** |  | | | | **Address:** | | | | | |
| **Date of Birth:** |  | | | |
| **NHS Number:** |  | | | |
| **Daytime Tel.** |  | | | | **Alternate Tel.** | | |  | | |
| **Practice & GP Details** | | | | | | | | | | |
| **Practice Name** | | | | **Referring GP** | | |  | | | |
| **Referral Date** | | | | **Referrer name and role (if not the GP)** | | |  | | | |
| **Nature of Continence problem/symptoms** | | | | | | | | | | |
| **Duration:** | | | | | | | | | | |
| **Special Requirements** e.g. Interpreter, Carer or family member needs to be present during assessment | | | | | | | | | | |
| **Other Factors Contributing to Continence Problems:** | | | | | | | | | | |
| Mobility/ Dexterity  Cognitive Impairment  Mental Health  Environmental | | | | | | **Bowel Problems** | | | | |
| **Obstetric History** | | | | | | **Previous Investigations** | | | | |
| Childbirth within last 12 months? | | | **YES / NO** | | |  | | | **YES / NO** | |
| **NOTES:** | | | | | | | | | | |
| **Medication (please attach current list, if share not in place through Systmone)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Past Medical History (please attach, if share not in place through Systmone )** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Allergies:** | | | | | | | | | | |
| **Examination Finding:** | | | | | | | | | | |
| Abdominal  Vaginal: | | | | | | | | | | |
| **It is essential to urine dipstick test in all women presenting with urinary incontinence to detect the presence of blood, glucose, protein, leucocytes and nitrites in the urine NICE NG123** | | | | | | | | | | |
|  | |  | | **Date:** | | **Result:** | | | | |
| **Urine Dipstick** | | **YES / NO** | |  | |  | | | | |
| **MSU?** | | **YES / NO** | |  | |  | | | | |
| **Urine Cytology?** | | **YES / NO** | |  | |  | | | | |
| Once referred into the HDFT Integrated Continence Pathway further tests and/ or consultant referral may be judged to be appropriate by specialist nurses/physios. Referral into the pathway assumes that this process is acceptable to you. | | | | | | **Signature of referrer** | | | | |

**Please send to: Single Point of Access**

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