**Hull & East Riding Bladder & Bowel Health Service**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | Date of Referral: | | | | |
| Job Title: | | | | | | | | | | |
| Address & contact number/email of referrer: | | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | |
| Registered GP: | | | | | | GP Practice Address: | | | | |
| Title: | Forename: | | | | | Surname: | | | Known as: | |
| Date of Birth: | | | | | | NHS Number: | | | | |
| Gender: | | | | | | Ethnicity: | | | | |
| Religion: | | | | |
| Address: | | | | | | | | | | |
| Patient home number: | | | | | | Patient mobile number: | | | | |
| Preferred contact number: Home  Mobile | | | | | | Email address: | | | | |
| Lives alone/carers/nursing home/  residential home: | | | | | | Next of Kin/Carer/Emergency contact: | | | | |
| Is the patient housebound? | | | | | | Yes | | No | | |
| What is the patient’s mobility status? **(Please give details)** | | | | | | | | | | |
| Consent to contact via SMS | | | | | | Yes | | No | | |
| Consent to contact via Email | | | | | | Yes | | No | | |
| Consent to share medical information: | | | | | | Yes | | No | | |
| Translator required: | | | Yes | | | No | | Language required\*: | | |
| Chaperone required: | | | Yes | | | | | No | | |
| Accessible information needs: | | | Yes | | | No | | Detail needs: | | |
| Diagnosis: | | | Client aware of diagnosis? | | | Yes | | No | | |
| Are there any other services involved in patient’s care  Are they currently under a hospital consultant ? | | | Yes | | | No | | Don’t know | | |
| Yes | | | No | | Don’t know | | |
| **(If yes give details)** | | | | | | | | | | |
| **SUPPORTING INFORMATION** | | | | | | | | | | |
| Is there a Lone working risk? | | | | | Yes | | | | | No |
| Is there a Safeguarding risk? | | | | | Yes | | | | | No |
| Has the patient given consent for the referral? | | | | | Yes | | | | | No |
| Any concerns re Mental Capacity? | | | | | Yes | | | | | No |
| **ReSPECT** document in place? | | | Yes | | No | | | **(If yes give details)** | | |
| Smoking: | | | Yes | | No | | | Don’t know | | |
| Are there any skin integrity issues/at risk of ? | | | Yes | | No | | | **(If yes give details)** | | |
| **ESSENTIAL INFORMATION** | | | | | | | | | | |
| Has a recent urinalysis been completed ? | | Yes | | No | | | **(If yes give details of the results):** | | | |
| Is there any previous or recent history of recurrent UTI? | | | | | | | Yes | | | No |
| **MEDICAL HISTORY (Including current Medication & Surgical History)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | | | | |
|  | | | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | | |
| **\*Please note clients with blood in stools or non-specific haematuria should be referred to secondary care\*** | | | | | | | | | | |
| **Describe Bowel problem/symptoms:** | | | | | | | | | | |
| **Describe Bladder problem/symptoms:** | | | | | | | | | | |

**To make a referral please send via email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net)or Telephone Bladder & Bowel Service: 01482 247111

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***