**Paediatric Continence Service Referral Form**

**Age 4 to 17 years**

**Please return by e-mail to:** **epunft.paediatriccontinence@nhs.net**

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| Paediatric Continence ServiceThe Old PharmacyRochford HospitalUnion LaneRochfordEssex SS4 1RB Telephone: 01702 372073 | **Office use only:** |
| **Accepted/Appointment:** |  |
| **Declined/Inappropriate:**  |  |
| **Returned to referrer:** |  |

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|  **Date of referral:**  |  |

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| **Patient Details** |
| NHS Number: |  |
| First Name:  |  | Last Name: |  |
| Address: |  |
| Postcode: |  | Home Telephone: |  |
| Date of Birth: |  | Age: |  | Gender –  | Male |  | Female |  |
| Parent /Carer Name: |  | Mobile: |  |
| School Name: |  |
| Ethnicity:  |  |
| Learning/Physical Disability: |  |
| Communication Difficulties: |  |
| Translator Required:  | Yes |  | No |  |  |
| Child Protection/LAC/Vulnerable: |  |

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| **GP/Paediatrician Details** |
| **Examined to exclude red flags** | Yes |  | No |  |  |
| GP/Paediatrician Name:  |  |
| Address or F Code: |  |
| Telephone: |  |

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| **Reason for Referral** *(Please specify)* |
|  |
| Products in use:  |  |

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| **Referrers Details**  |
| Referrer Name: |  | Designation: |  |
| Address: |  |
| Telephone: |  | Mobile: |  |
| Secure e-mail: |  |