**Paediatric Continence Service Referral Form**

**Age 4 to 17 years**

**Please return by e-mail to:** [**epunft.paediatriccontinence@nhs.net**](mailto:epunft.paediatriccontinence@nhs.net)

|  |  |  |
| --- | --- | --- |
| Paediatric Continence Service  The Old Pharmacy  Rochford Hospital  Union Lane  Rochford  Essex SS4 1RB  Telephone: 01702 372073 | **Office use only:** | |
| **Accepted/Appointment:** |  |
| **Declined/Inappropriate:** |  |
| **Returned to referrer:** |  |

|  |  |
| --- | --- |
| **Date of referral:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | | | |  | | | | | | | | | | | | | | | |

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

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

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