**Single Point of Access**

**Woking Community Hospital**

**Heathside Road**

**Woking**

**GU22 7HS**

**csh.spareferrals@nhs.net**

**Tel:-0330 726 0333**

**csh.spareferrals@nhs.net**

**Telephone : 01483 782150 0 726 0333:**

**csh.spareferrals@nhs.net**

**Telephone : 01483 782150**

**Fax: 0208 394 3863 Tel: 0208 394 3868**

**(Office hours: 8am – 6pm Mon-Fri)**

Continence Service Referral Form

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#### PLEASE COMPLETE ALL SECTIONS OF THE REFERRAL FORM.

#### This will help us to direct you to the most appropriate clinic/setting

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| --- |
| Client Details |
| Surname |  | Miss / Mrs / Ms / Mr / Dr / other |
| Forename |  | Date of Birth |  |
| NHS Number |  | Gender  | Female |
| Address & Postcode |  |  |
|  |  |  |
| Home Telephone Number |  | Alternative Daytime Telephone Contact Number |  |
| Registered GPName |  | GP TelephoneNumber |  |  |
| Surgery / Practice Address & Postcode |  |  |
|  |  |

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| **Referrer Details** |
| GP [ ]  Self or Family Referral [ ]  Community Hospital [ ]  Nursing Home [ ]  Residential Home [ ] Community Health Care Professional [ ]  Secondary Care [ ]  Social Care [ ]  Mental Health/Disability agency [ ]   |
| Name & address of Referrer: |  |
| Job Title: |  | Contact Number: |  |
| Signature :  |  | Date of referral: |  |
| **Reason For Referral – please tick all relevant** |
| Bladder symptoms **[ ]**  Bowel symtoms **[ ]** Prolapse with Bladder or Bowel Symptoms **[ ]** Pelvic pain **[ ]** Pelvic Floor weakness **[ ]**  Prolapse **[ ]**  Other (please state).................................Details/other relevant additional information |
| **Appointment Type**  |
| All Continence Assessments are carried out over the telephone by appointment only. |
| Relevant Medical Details – Please tick all relevant |
| Have you ever been diagnosed with  | Alzheimer’s Disease/Dementia Mild **[ ]** Moderate [ ] Severe **[ ]** **[ ]** Parkinson’s Disease **[ ]** Multiple Sclerosis**[ ]** Stroke**[ ]** Lower back or hip pain (currently active)**[ ]** Other long term condition (please state)...........................**[ ]** Any pelvic surgery (please state)............MRSA Yes [ ]  No **[ ]**  Unknown  **[ ]**  C.Diff Yes [ ] No **[ ]**  Unknown  **[ ]**    |  |

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| Other Services or Agencies Involved – Please tick all relevant |
| Have you ever been seen by | **[ ]** Urology Consultant**[ ]** Colorectal Consultant**[ ]** Multiple Sclerosis Nurse**[ ]** Parkinson’s Disease Nurse**[ ]** Community Nursing Services**[ ]** Social Services**[ ]** Continence Service – date seen............................. |  |

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| --- |
| **ETHNICITY** |
| A: White – British  |
| B: White - Irish |
| C: White – Any Other |
| D: Mixed – White & Black Caribbean |
| E: Mixed – White & Black African |
| F: Mixed – White & Asian |
| G: Mixed – Any other |
| H: Indian |
| J: Pakistani |
| K: Bangladeshi  |
| L: Any other Asian background |
| M: Caribbean |
| N: African |
| P: Any other black background |
| R: Chinese |
| S: Any other ethnic group |
| Z: Not stated  |

**Please return your completed form to: CSH Single Point of Access, Woking Community Hospital, Heathside Road, Woking GU22 7HS Email:** **csh.spareferrals@nhs.net** **Telephone : 0203 726 0333**