**Wiltshire Continence Service Referral**

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | NHS No. |  |
| Address |  | Date of Birth |  |
| Home Telephone |  |
| Work Telephone |  |
| Email |  | Mobile Telephone |  |

**Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Clinician |  | Date of Referral |  |
| GP Practice |  | Dates Not Available |  |
| Address |  | Telephone |  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required?: | Yes |  | No |  | Wheelchair access required? | Yes |  | No |  |
| Language: |  | | | | Learning Disability: |  | | | |
| Hearing: |  | | | | Other disability needing consideration: |  | | | |
| Vision: |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

**Reason for Referral/ Treatment Plan:**

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**Investigations:**

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| Urinalysis done  (please tick) Results: Leucocytes  Nitrites  Protein  pH  Specific Gravity       Ketones  Glucose |
| **Please exclude any gross abnormality-**  Vaginal examination results if done:  Bi-manual examination results if done: |
| Rectal examination results if done: |

**Past Medical History:**

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**Allergies:**

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| --- |
|  |

**Medication:**

|  |  |
| --- | --- |
|  |  |
|  |  |

**Please refer via eRS or email ( professional use only)** [**whc.wiltshirecontinence@nhs.net**](mailto:whc.wiltshirecontinence@nhs.net)**.**

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| **South/East Wiltshire**  Wiltshire Continence Service  Central Health Clinic  Avon Approach  Castle Street  Salisbury  Wiltshire  SP1 3SL | **West/North Wiltshire**  Wiltshire Continence Service  Trowbridge Hospital  Adcroft Street  Trowbridge  Wiltshire  BA14 8PH |