**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:**

|  |
| --- |
|        |

**Investigations:**

|  |
| --- |
| 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:**

|  |
| --- |
|       |

**Allergies:**

|  |
| --- |
|       |

**Medication:**

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

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

|  |  |
| --- | --- |
| **South/East Wiltshire** Wiltshire Continence ServiceCentral Health ClinicAvon ApproachCastle StreetSalisburyWiltshireSP1 3SL | **West/North Wiltshire**Wiltshire Continence ServiceTrowbridge HospitalAdcroft StreetTrowbridgeWiltshireBA14 8PH |