

Referral Form

Continence Advisory & Women’s Health Physiotherapy Service

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| Client details: | | | |
| Surname: | First name: | | Title: Dr/Mr/Mrs/Miss/Ms |
| Date of birth: | Male / female | | NHS No: |
| Ethnicity: | Interpreter required: Yes / No | | Preferred language: |
| Address:  Postcode:  Telephone No: Mobile: | | GP Name:  GP Address:  Postcode:  Telephone No: | |
| Has this referral been discussed and agreed with the client? Yes / No | | | |
| Mobilises independently: Yes / No | | Transport required: Yes / No | |

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| Reason(s) for referral: | | | | | |
| Urinary problems | | Voiding problems | | Vaginal pain / problems | |
|  | Stress incontinence |  | Sensation of incomplete emptying |  | Dragging sensation / heaviness |
|  | Urge incontinence |  | Poor or intermittent stream |  | Pelvic organ prolapse, type if known: |
|  | Mixed incontinence |  | Hesitancy / straining |  | Cystocoele / urethrocoele |
|  | Coital incontinence |  | Post micturition dribbling |  | Rectocoele / enterocoele |
|  | Overactive bladder | Bowel problems | |  | Uterine / vault prolapse |
|  | Frequency |  | Faecal incontinence |  | Vaginismus |
|  | Urgency |  | Faecal urgency |  | Vulvodynia |
|  | Nocturia |  | Flatus incontinence |  | Dyspareunia |
|  |  |  | Constipation |  | Weak pelvic floor muscles / laxity |
| Pelvic girdle pain / abdominal problems | | | |  | 1ᵒ / 2ᵒ perineal tear, date: |
|  | Diastasis of rectus abdominis | | |  | 3ᵒ perineal tear, date: |
|  | Antenatal pelvic girdle pain, no. of weeks pregnant /40 | | |  | 4ᵒ perineal tear, date: |
|  | Postnatal pelvic girdle pain, date delivered: | | |  | Extended episiotomy, date: |
| Duration of problem / additional information: | | | | | |

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| Past medical / surgical history: |
| (please complete or attach / fax a print out) |
| Current medication and dosage: |
| (please complete or attach / fax a print out) |
| Investigations / examinations findings: |
| Urinalysis results normal: Yes / No |
| MSU result (if dipstix normal): |
| Vaginal examination: |
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| Rectal examination: |
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| Abdominal examination: |
| BMI: |
| Urodynamics: |
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| Services / support currently being received (details & contact names / numbers) |
| (Personal care, community nurse, community matron, day centre, mental health, consultant, midwife) |

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| Referrer details - Healthcare Professional, GP etc. For Self-referral please enter your own details: | | | |
| Name: | Signature: | Date: | |
| Contact No: | Job title: | Organisation: | |
| Address: | | Report attached: Yes / No | |
| Have you been seen by Continence Advisory / Women’s Health Physiotherapy Service before? Yes / No | | |  |
| If Yes, then please state the date when you attended the service: | |  | |

The service accepts referrals for:

* Adults with bladder, bowel, pelvic organ prolapse, pelvic floor dysfunction or pelvic pain.
* Children requiring a Level 2 assessment of bladder and bowel problems that have not responded to the initial treatment at level 1 with the Health Visiting Team or School Nurse.

Please note, refer:

* Adult housebound clients to the District Nursing Service
* Children aged 3-5 with special needs to the Health Visiting Team
* Children aged 5-18 to the School Nurse
* Children aged 5-18 with bedwetting to the Enuresis Service (West Ham Lane Health Centre)
* Ante/postnatal women with low back pain to the Musculoskeletal Physiotherapy Service (29 Romford Rd)
* Clients with visible haematuria, microscopic haematuria (40yrs+), recurrent or persistent UTI associated with haematuria or suspect pelvic mass, directly to secondary care.

**Please send or fax the completed referral form to:**

**Continence Advisory & Women’s Health Physiotherapy Service**

East Ham Care Centre, Shrewsbury Road, London, E7 8QP

**Tel:** 020 8475 2012 **Fax:** 020 8475 2063

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| Triage (office use only): | | |
| Triaged by: | Signature: | Date: |
| Outcome: | | |