**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:**

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

**(Office hours: 8am – 6pm Mon-Fri)**

Continence Service Referral Form

#### 

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 GP  Name |  | GP Telephone  Number | |  |  |
| 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 | | | |  |

|  |  |  |
| --- | --- | --- |
| 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............................. |  |

|  |
| --- |
| **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**](mailto:csh.spareferrals@nhs.net) **Telephone : 0203 726 0333**