

**Paediatric continence referral form**

# Please note important referral criteria below:

* Referrals are only accepted from healthcare professionals (GP/ school health/health visiting/ community/hospital consultants and allied professionals).
* Referrer must demonstrate that there has been Level 1 intervention for at least 3 months prior to referral for toilet training and constipation. [Please see resource pack for more information](https://www.bbuk.org.uk/wp-content/uploads/2019/03/Level-one-resource-pack-for-childrens-bladder-and-bowel-care.pdf)
* For children being referred for toilet training or assessment for continence products, parents need to first attend a free workshop run by our service. Please signpost parents to our [website to book the workshop](https://cypf.berkshirehealthcare.nhs.uk/our-services/other-services/paediatric-continence/).
* Referrer needs to demonstrate that a physical assessment has been completed to rule out any underlying concerns or exclusion criteria (see below) ie have they been seen by a GP/paediatrician.
* Nocturnal Enuresis eligibility: children who are over 9 years old who have had input from GP/School Nursing Enuresis Service and have had at least 6 months of desmopressin.

# Exclusion criteria, or requires treatment prior to referral (Nice, 2014)

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| **Red Flag symptoms** | **Amber Flag symptoms** |
| Timing of onset reported from birth or first few weeks of life  Failure to pass meconium/delay (>48 hours after birth)  Ribbon stools  Previously undiagnosed weakness in legs, loco motor delay  Abdominal distension with vomiting | Faltering growth  Evidence of child maltreatment |



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| PATIENT’S DETAILS | | |
| **Name:** | **DOB:** | |
| **Address:**  **Post Code:** | **Ethnic origin:**  **Interpreter required: Yes/ No Language:** | |
| **GP name:**  **Surgery name:** | |
| **Telephone:** | **NHS No:** | |
| **Parent/carer:**  **Relationship to child:** | **Date of referral:** | |
| **School nurse name: School name and address:**  **Email:**  **Tel:** | | |
| **Paediatrician and other professionals involved** | | |
| **Essential information required**   * **Reason for referral - including diagnosis if known and relevant medical history/investigations:** * **Previous input within the community such as toilet training:** | | |
| **Has this child been subject to a CAF/TAC process? Are the family known to social services?**  **Are there any risks to home visiting?** | | |
| REFERRER DETAILS | | |
| **Name:** | | **Role:** |
| **Work base/address**  **Postcode:** | | **Telephone:**  **Email:** |

**Please email this form to:** [**integratedhub@berkshire.nhs.uk**](mailto:integratedhub@berkshire.nhs.uk)

**Or send by fax to the Health Hub: 0300 365 0400**