**Paediatric continence referral form**

# Please note:

* 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
* Referrer needs to demonstrate that a physical assessment has been completed to rule out any underlying concerns or exclusion criteria (see below)

# 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 lifeFailure to pass meconium/delay (>48 hours after birth)Ribbon stoolsPreviously undiagnosed weakness in legs, loco motor delayAbdominal distension with vomiting | Faltering growthEvidence 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 No:** | **NHS No:** |
| **Parent/carer:****Relationship to child:** | **Date of referral:** |
| **School nurse name: School name and address:****Email:****Tel No:** |
| **Paediatrician and other professionals involved** |
| **Reason for referral, including diagnosis if known and relevant medical history. Also include details of previous input within the community such as toilet training or relevant investigations: (**please include copies of relevant medical reports) |
| **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****Post Code:** | **Telephone:****Email:** |

**Please fax this form to the Health Hub on 0300 365 0400 Or email to** **integratedhub@berkshire.nhs.uk**