

**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 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 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**](mailto:integratedhub@berkshire.nhs.uk)