[Sussex Community NHS Trust](http://thepulse/)

community bladder and bowel service

**Referral Form**

*Use this form only to refer patients who are willing and capable to attend for Erectile Dysfunction, Lower Tract Symptoms, and Bladder and Bowel Assessment. Please complete all sections for prompt processing of referral.*

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| --- | --- |
| **Exclusion Criteria** | |
| Refer or treat appropriately:   * Visible Haematuria * Suspected Pelvic Mass * Retention * Uncontrolled Diabetes * Prostate feels abnormal * Urological cancer is suspected | * + Recurrent/persisting Haematuria   + Symptomatic/significant Prolapse   + Prostatic Hypertrophy   + Sterile pyuria   + Severe Constipation |

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Details | | | |
| Forename | Surname | Date of Birth |  |
| Patient’s current Address | | Daytime Tel no: | Mobile Tel no: |
| NHS number | |
| Hospital number | |
| Postcode | | Ethnicity | |
| If the patient requires an interpreter please state language required. | | Please state any other special needs. | |
| Is the patient housebound?  Yes No | |
| Access details | | Relevant contact details | |

|  |  |
| --- | --- |
| Practice Details | |
| Practice address  Postcode | Referring GP |
| Date of GP consultation |
| Practice Tel No  Fax no: |

|  |
| --- |
| Information required |

|  |  |  |
| --- | --- | --- |
| Presenting symptoms | | |
| ***Please describe*** | | |
|  | | |
| Investigations | | |
| PSA | Yes Result: | No |
| IPSS Score |  |  |
| Bladder Diary (Attach) |  |  |
| Palpable Bladder | Yes | No |
| Rectal Examination Outcome:  Ensure constipation is excluded |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Erectile Dysfunction | | | |
| B.P. | Urine analysis | Genital examination | Fasting lipids |
| Testosterone |  |  |  |

**For the referral to the E.D. clinic to be processed the above investigations MUST to be recorded**

|  |
| --- |
| Past Medical History |
| ***Please attach full medical summary to referral.*** |

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| Medications |
| ***Please attach current medication list.*** |

**Past medical history and medications MUST be included for all referrals**

|  |
| --- |
| **Reason for referral, ie.** Assessment of bladder & bowel/continence needs/management advice: |

Name………………………………………Signature………………………………Date…………………

For any advice please phone the service on **Tel No 01273 265912**

Send completed referral and all required information to:

**Community Bladder and Bowel Service.**

**Hove Polylclinic**

**Nevill Ave**

**or Fax to 01273 254139 or email to** [**sdo-tr.continence@nhs.net**](mailto:sdo-tr.continence@nhs.net)