Continence Advisory Service

Castle Point and Rochford NHS
Primary Care Trust

Referral Form

Please print and complete all sections or it will be returned

Referred By Name Contact Tel No.	Date of Referral	Address / Ward/ Department
Patients Details Title Surname Forenames Address Postcode Tel No Date of Birth	Male / Female	**GP Details** Name Address Tel No. **Carer / Next of Kin** Name Relationship Contact Address Tel No.
Hospital Details (where applicable) Hospital No Hospital Consultant	Reason for admission Hospital Discharge Date	
Reason for Referral		
Medical History (Past & Present) **Medication** **Urinalysis** **Excluded/Treated** Vaginitis Impaction Constipation UTI Retention		
Other relevant information i.e. Communication Difficulties / Disabilities **Agency input** – Social Services District Nurse Other please state		
Signature This form must be signed by a Qualified Health Care professional	**Print Name**	**Designation**
NB Community Nurses / Ward Nurses please attach copy of Continence Care Pathway *** **IF PATIENT WILL HAVE D/N REFER DIRECT TO D/N** ***		
Send to; Continence Advisory Service, 3rd Floor, Phoenix House Christopher Martin Road Basildon, Essex, SS14 3EZ	For Office Use	