

**PLEASE RETURN COMPLETED FORM TO:**

Bladder & Bowel Service

5 Curzon Road

Southport

PR8 6PL

Telephone 01704 387262

Fax 01704 387674

Email: [Southportandformby.spa@merseycare.nhs.uk](mailto:Southportandformby.spa@merseycare.nhs.uk) or [mcn-tr.southportandformbyspoa@nhs.net](mailto:mcn-tr.southportandformbyspoa@nhs.net)

#### NURSING AND RESIDENTIAL HOME CONTINENCE REFERRAL FORM

**It is essential that this form is completed fully in order for the resident to receive appropriate continence care. This may or may not result in provision of continence products.**

**Incomplete forms will not be processed.**

|  |  |
| --- | --- |
| Name ……………………………………………….  Title …………………Date of birth………………..  Name of Home ……………………………………  Address and Postcode…………………………..  ………………………………………….………….  ………………………………………………………  Telephone number………………………………………….. | NHS number….………………………………  Gender……….. Ethnicity ………………….  GP Surgery:……………………………..........  Date of admission to home …………………  Previous address ……………………………  …………………………………………………  …………………………………………………. |

**Full medical history:**

……………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

**Current medication (attach copy of MAR sheet if preferred)**

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

**Name………………………………………………………………….NHS number………………………………………….**

**Any known allergies** …………………………………………………………………………………………………………….

Presenting continence problem – include duration and current management as well as any relevant factors affecting continence, e.g. mobility, resident’s understanding of situation, ability to manage clothing / pads. Please provide as much information as possible as this will help to determine the product prescribed.

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………

**Daily fluid intake (in mls**)………………………… **Types of fluid**……………………………………………………..

**State regular bowel habit (with reference to Bristol Stool chart**)………………………………………………

**Any faecal incontinence**

………………………………………………………………………………………………………………….

**Hip measurement (cms)** ………………………… **Waist measurement (cms**)……………………………..

**Please add any further information, which you feel may be useful:**

………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………. …………………………………………………………………………………………………………………………..

**Signature** ……………………………….……… **Print name** ……………………………………………………..

**Designation**….................................................................. **Date....................................................................**

**OFFICE USE ONLY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Product Order** | | | | | | |
|  | ***Product Code*** | ***Quantity per 24-hour period*** | ***Inputting***  ***Date*** | ***First Delivery***  ***Due*** | | ***Inputted by*** |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  |  |  |  | |  |  |
|  | | | | | | |