***Please read referral criteria below prior to completing this referral form.***

|  |  |
| --- | --- |
| *Has parent consented to this referral?* | *Yes / No* |
| **Area** | **E-mail referral to** |
| Lambeth and Southwark | **gst-tr.paediatriccontinencenurse@nhs.net** |

***Date of referral:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1. Child and Family Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **First name:** |  | **Gender:** |  |
| **Last name:** |  | **Ethnicity:** |  |
| **DOB:** |  |  |  |
| **NHS number:** |  |  |  |
| **Address:****Post Code:** | **Home phone:****Mobile:** | **Email address:** |
| **Parent/carers name:** |  | **First language:** |  |
| **Relationship to child:** |  | **Is an interpreter required?** |  |
| **Health visitor/School Nurse:** |  |
| **Based at:** |  |
| **How does the child communicate:** | **Verbal:** Yes / No**Makaton:** Yes / No**PECS:** Yes / No**Switch:** Yes / No | **Does the parent have internet access and facility to carry out virtual appointments?**Yes / No |

**GP Details**

|  |  |
| --- | --- |
| **GP Name:** |  |
| **GP Address:** |  |
| **GP Telephone:** |  |

**Section 2. MDT/Professionals involved with family.**

|  |  |  |
| --- | --- | --- |
| **Referrer Name:** | **Designation:** | **Contact Details:** |
| **Hospital Consultant:** |  |
| **Physiotherapist:** |  |
| **Occupational Therapist:** |  |
| **Speech & Language Therapist:** |  |
| **Social Worker:** |  |
| **CPP/CIN plan:** | **Category:** |

**Section 3. Referral Information**

|  |  |
| --- | --- |
| **Does the child have Additional needs:** | Yes / No |
| **Diagnosis and relevant previous history:** |  |
| **Does the child have any known bladder/bowel dysfunction? (for example neuropathic bladder and bowel, constipation, mega rectum)** |  |
| **Reason for referral:** |  |

**Section 4. School Details**

|  |  |
| --- | --- |
| **School Name:** |  |
| **Address:** |  |
| **Contact Name:** |  |
| **Contact Number:** |  |

***Please note, referrals will be triaged and processed as appropriate within 10 working days.***

**Thank you**

Jane Thomas

Clinical Nurse Specialist Paediatric Continence - Lambeth and Southwark.

**Criteria for referral to Lambeth/Southwark continence service**

*If referral is regarding end of life continence care, please complete sections 1&3 and send as urgent referral to the email address above.*

**Inclusion criteria**

* Children who attend one of the following schools - Cherry Garden, The Livity, Michael Tippett and Tuke, who require assessment of their continence needs.
* Children with **Complex needs** who attend a school or are being Home schooled other than listed above, or whose GP is in Lambeth or Southwark who require continence assessment.
* Children must be 5 years old and upwards to around 17 when they will be transitioning to adult continence services.
* Children with complex needs who require assessment will have a period of least six month toilet training (where appropriate) prior to being prescribed continence products as per ‘Guidance for the provision of continence containment products’ policy.
* *Children/parents who require toilet training advice when agreed.*

**Exclusion criteria**

* Families whose GP is not in Lambeth or Southwark – *Refer to their local Continence service.*
* Children who do not have complex needs (as above) – *Refer to ELCH or SN Enuresis clinic.*
* Children under 5 years old – *Refer to HV*
* Children who attend MLD school (Highshore, Haymerle, Turney, Lansdowne, Spa, Elm Court) and who have difficulties with bedwetting only – *Refer to SN Enuresis clinic.*

**Administration only**

Date referral received ……………………………………….

## Referral accepted [ ]

Referral rejected [ ]

Reason for rejection:

Incomplete referral [ ]

Does not attend Cherry Garden/The Livity/Tuke/Michael Tippet [ ]

GP out of borough [ ]

Other [ ]

Action taken ……………………………………………………………………………………..

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

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