**Referral form for Children with Night-time or Daytime Wetting**

**NURSE LED PATHWAYS**

**REFERRALS WILL BE ONLY ACCEPTED FROM GP OR PAEDIATRICIANS**

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| **Date of Referral:** |       |
| **Consent** | [ ]  | I have gained the appropriate informed consent from the Parent/Carer/Child/Young Person, including transfer between these two pathways  |
| **Child’s Details** *(please complete with as much information as possible) \*essential information* |
| **\*Name** |       | **\*NHS Number** |       |
| **\*Address** |       | **\*Contact No.** |       |
| **\*DOB** |       | **Own Gender Definition** |       | **Birth Gender** |  |
| **\*School/****Nursery** | **If in Specialist Inclusion Learning Centre (SILC) refer to nurse in the SILC** | **GP Practice** |       |
| **Ethnicity** |       | **\*Interpreter Required?** | **Y** [ ]  **N** [ ]  | **\*Language** |       |
| **Religion** |  | **\*Other Communication Needs for parent or child?** | **Y** [ ]  **N** [ ]  |       |
| **Reason for referral** **(select only one – if the child has both daytime and night-time wetting please select daytime as this needs to be addressed first)** |
| Night-time Wetting only (Child is age 5-19)*Click here for One Minute Guide* | [ ]  |
| Daytime Wetting (Child is age 5-16, including daytime urgency and frequency)*Click here for One Minute Guide* | [ ]  |

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| **\*Confirm that ALL following assessments have been completed by the Referrer. The referral will be declined if these are not completed**

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|  | Complete boxes to confirm ALL assessments are completed and no abnormalities found |
| Urinalysis completed to exclude diabetes mellitus/UTI | [ ]  |
| Exclude neurological link eg spinal anomalies. Check for chronic lower limb neurology including reflexes and appearance of spine | [ ]  |
| Exclude constant dribbling of urine | [ ]  |
| Exclude abdominal mass/large bladder | [ ]  |
| Exclude family history of diagnosed Renal Disease to rule out renal causes | [ ]  |
| Exclude faltering growth | [ ]  |

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| **\*Presentation including History:****Please check for mild constipation and start on laxative if this is suspected – over half of children we see with wetting problems are slightly constipated. For constipation which does not respond to consistent laxative medication for 3 months refer into ICAN constipation pathway on the ICAN referral form as the constipation needs addressing first.**      |

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| **\*Safeguarding Concerns:**   | Yes [ ]  No [ ]  |
| **If yes, please detail:**      |
| **Are other services/ professionals involved?** | Yes [ ]  No [ ]  |
| **If yes, please provide contact details**       |
| **Parent/Carer/Child Contact Details** *(please complete with as much information as possible)* |
| **\*Who will be the main point of contact for this referral?** |  Parent/Carer [ ]  Child/Young Person [ ]   |
| **\*Name:**(if different) |       | **\*Contact No:** |       | **OtherContact No:** |       |
| **\*Address:**(if different) |       | **\*Postcode:**(if different) |       |
| **Referrer’s Details** *(please complete with as much information as possible)**PLEASE NOTE: ONLY GP/PAEDIATRICIAN CAN REFER INTO THESE SERVICES* |
| **\*Name of** **Referring Service:** |       |
| **\*Name of referring GP or Paediatrician:** |       | **\*Phone Number** |       |
| **\*Practice Address** |       | **Postcode:** |       |

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| **How do I make a referral?**Referrals can be made by completing this form and sending by:Secure email to **ican.referrals@nhs.net**Task in SystmOne Child Health Unit: Task Group **‘Infant Records’** |