**Primary Care Referral Form for Child & Young Persons Bowel and Bladder Service - Paediatrics**

**\*\* Please refer to Guidance Notes before completing \*\***

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| **Patient Information** |
| **Patient Name** |  | **Ethnicity** |  |
| **NHS Number** |  | **First Language** |  |
| **DOB** |  | **Interpreter required?** |  |
| **Age** |  | **Registered GP** |  |
| **Gender** |  | **GP Practice Address** |  |
| **Address** |  | **HV / School Nurse** |  |
| **Telephone** |  | **School / Nursery** |  |
| **Email** |  | **Social Worker** |  |

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| **Referral Criteria** |
| **Please ensure that all 6 referral criteria are checked – the referral will not be accepted if these are not complete.** |
| **1.** | **Must have a GP in the former Vale of York area** |[ ]
| **2.** | **Must have had red flags ruled out by a GP or Paediatrician.****Red flags are:*** **Symptoms that commence from birth or in the first few weeks.**
* **Failure or delay (>first 48 hours at term) in passing meconium.**
* **Ribbon stools.**
* **Leg weakness or locomotor delay.**
* **Abdominal distension with vomiting.**
* **Abnormal examination of findings including abnormal appearance of anus, gross abdominal distension, abnormal gluteal muscles, scoliosis, sacral agenesis, limb deformity including talipes.**
* **Abnormal reflexes.**
 |[ ]
| **3.** | **Must have a bowel and bladder problem** |[ ]
| **4.** | **Children with constipation / soiling, must have been commenced on laxative management and signposted to the** [**ERIC**](https://eric.org.uk/) **website and** [**The Poo Nurses**](https://www.youtube.com/watch?v=9WqxJqLmKao) **video on YouTube.** |[ ]
|  | **Not applicable – bladder only.** |[ ]

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| **5.** | **Please tick one of the following:** |  |
|  | **a.** | **Vulnerable child on a Child Protection Plan / Child in Need / current safeguarding concerns** |[ ]
|  | **b.** | **No current safeguarding concerns** |[ ]
| **6.** | **Must be under the age of 19** |[ ]

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| **Contact Information of Parent / Carer** |
| Name of Parent / Carer | Relationship to Child/YP | Contact Details | Parental Responsibility? |
|  |  |  |  |
|  |  |  |  |
| Are the patient’s parents / carers aware of this referral? | Yes |[ ]  No |[ ]
| Have they consented to this referral? | Yes |[ ]  No |[ ]

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| **Referral Details** |
| Problem / diagnosis: |  |
| How long has this problem been present? |  |
| What treatment has been offered? |  |
| Have any investigations been carried out? If so, what were the results? |  |
| Has the child developmental, attention or learning difficulties? |  |
| Are there any family problems or vulnerable child issues? |  |
| **Please indicate the following:** |
| Urinalysis result: |  |
| Constipation Symptoms: | Yes |[ ]  No |[ ]
| **Please document examination findings (include external genitals and neurological examination):** |
|  |
| **Please add any further information here:** |
|  |