NOCTURNAL ENURESIS SERVICE REFERRAL FORM

Referrals will be accepted from GPs, Paediatricians, or clinicians on their behalf, for example: Nurse Practitioners or School Nurses.

This form is designed to be completed and sent electronically via secure email. Each section will expand as you add text.

Please complete all sections, providing as much information as possible to support your referral.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | |
| Surname: |  | First Name: |  | | DOB: |  |
| Address: |  | | | | | |
| Email: |  | | Contact No: |  | | |
| NHS No: |  | | Gender: | Choose an item. | | |
| School: |  | | Ethnicity: |  | | |
| GP: |  | | | | | |
| Interpreter required? Choose an item. If yes, please specify language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **Referral Information** |
|  |
| Are there any previous or current history of constipation? Choose an item.  If yes, please detail history & treatment |
| Are there associated significant emotional / medical problems? Choose an item.  If yes, please describe: |
| Does the child or young person have a Learning Disability? Choose an item.  If yes, please describe: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer’s Details** | | | |
| Name: |  | | |
| Address: |  | | |
| Email: |  | Contact No: |  |
| Date: |  | | |

Please send the completed form via email to [EnuresisTeam@suffolk.gov.uk](mailto:EnuresisTeam@suffolk.gov.uk). This is our preferred method for receiving referrals. Alternatively it can be printed and sent to:

Nocturnal Enuresis Service

Allington Clinic

427 Woodbridge Road

Ipswich

IP4 4ER

Tel: 01473 260917

