**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**   |  |  | | --- | --- | |  | 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 |  | |
| **\*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:** |  | | **Other Contact 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’** |