ALLCARE COMMUNITY NURSING & DISABILITY SERVICES

Referral for Continence Service

Date: _____ Name of Referring Agency: _____

Name of referrer: _____ Authorised by: _____
(contact person)

Phone: _____ Mobile: _____

Email: _____

Client Details

Prefix: _____ First Name: _____ Last name: _____

DOB: _____ Age: _____ Current HCP Level: _____ Awaiting HCP Level: _____ STRC end date: _____

Address: _____ _____

Postcode: _____ Email: _____

Phone: _____ Mobile: _____

Nursing Home Client: ☐ Residential Home Client: ☐

Carer Details (*if applicable*)

Prefix: _____ First Name: _____ Last Name: _____

Lives with client: ☐ Yes ☐ No Relationship with client: _____

Phone: _____ Mobile: _____

Presenting continence issue/s: *(Please describe)*

_____

_____

When did the client become incontinent of urine or faeces?

_____

What other aids are used to help client pass urine?

_____

Is the client faecally incontinent? ☐ Yes ☐ No ☐ Unknown

Medical and Surgical History:

Current incontinence management (please advise type, size, brand and number of pants/pads being used):

Current medication:

Urinalysis

Has urinalysis been performed?	☐	Yes	☐	No	☐	Unknown
Is blood seen on urine?	☐	Yes	☐	No	☐	Unknown
Has the GP been informed of the results?	☐	Yes	☐	No	☐	Unknown
Is a urinary catheter in situ?	☐	Yes	☐	No	☐	Unknown

Financial Status: Private billing ☐ Home Care Package provider ☐ STRC Provider ☐

Person responsible for payment: _____ Phone: _____

Address: _____

Email: _____