CONFIDENTIAL

Continence Service Referral Form
5-19 years (from 4 if additional needs)

Child/Young Person:	**School:**
Date of Birth:	**Age:**
Address:	
Name of Parent / Carer with parental responsibility	
Preferred Contact Number:	
Ethnicity:	**Religion:**
Family Doctor/GP (If known):	
Language spoken:	

Are Parent's / Carer's / Child / Young Person aware of the referral? **YES** ☐ **NO** ☐

If No, please give reason:

Does the Parent/Carer have transport?

Details of continence issue:

What do you hope our service will achieve for this child / young person?

The Resource, Duncan Macmillan House,
Porchester Road, Nottingham NG3 6AA

Chair: Paul Devlin,
Chief Executive: Dr John Brewin

Other Support Services involved with Child / Young Person. Are there any safeguarding concerns?

Medical history (allergies):

Referrer details

Name **Designation**

Address

Telephone contact

Signature……Date……

Please complete this form and return it to – NandScontinence@nottshc.nhs.uk

For Office Use:

Referral received date			
Referral accepted/declined			
Allocated to		date	
Letter sent to referrer on			
Clinic appointment date			