

ENURESIS (BEDWETTING) REFERRAL FORM

PATIENT DETAILS

Surname : _____ First Name: _____

Address: _____

_____ Postcode : _____

Birthdate : ___ / ___ / ___ Sex : Male / Female Phone : _____

Next of Kin: _____

- 1 Is the enuresis primary (ie. never dry) or secondary in nature?
- 2 Are there any of the following features :
- | | | | |
|----|---|-----|----|
| a. | day time wetting | yes | no |
| b. | continuous dribbling | yes | no |
| c. | poor urinary stream in male | yes | no |
| d. | dysuria | yes | no |
| e. | backache | yes | no |
| f. | excessive thirst (waking at night to drink) | yes | no |
| g. | recent onset of polyuria | yes | no |
| h. | unexplained fevers | yes | no |
| i. | faecal incontinence or soiling | yes | no |
- 3 Is the child's growth normal? yes no
- 4 Are there associated significant emotional / medical problems?

- 5 On examination :
- | | |
|----|-----------------------|
| a. | blood pressure |
| b. | abdominal examination |
| c. | perineal examination |
- 6 Results of urinalysis or urine culture: _____
- 7 Interpreter required : yes no Language : _____
- 8 Does this child have features that concern you which require the assessment of a consultant paediatrician at PMH? Yes / No
- 9 If the reply to Question 8 is NO, the child will be referred directly to the Enuresis Clinic Nurse

Referring Doctors Name : _____

Address : _____

Date : ___ / ___ / ___ Signature : _____