**Paediatric Bladder and Bowel Health Referral Form**

**Child’s Details:**

**Name:** Click here to enter text.

**NHS No:** Click here to enter text.

**Date of Birth:** Click here to enter text.

**Address (include Post code):** Click here to enter text.

**Male:  Female:**

**Parent/carer Details:**

**Name:**

**Home Number:** Click here to enter text.

**Mobile Number:**

**1st Language:**

**Interpreter required:** Yes  No

**Has the parents’ consent been obtained:** Yes  No

**Contact Email address:**

**Practice Information:**

**Name of GP:**

**Practice Address:** Click here to enter text.

**Telephone Number:** Click here to enter text.

**School/Nursery Information:**

**School/Nursery:**

**School/nursery address:**

**Telephone Number:**

**Professionals/agencies involved:**

Include name, role and contact details.



**Education Health Care Plan:** Yes  No

**Please tick if appropriate:** Child Protection  Child in need  LAC Child

Reason for referral



Medical History



Treatment/Strategies already tried (if any) 

Current Medication



Allergies (including food)



**Referral Information**

**Referral by:**

**Designation:**

**Base/Tel No:**

**Date:**

***Please return this form to:*** *The Bladder and Bowel Health Service Team, Kings Court 1, First Floor, Charles Hastings Way, Worcester, WR5 1JR, Tel: 01905 681604*

*Email:* [*WHCNHS.bladderandbowelhealth@nhs.net*](mailto:WHCNHS.bladderandbowelhealth@nhs.net)