

Date of referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Community Bladder and Bowel Service

Witney Community Hospital

***Please print in capitals***

Welch Way

Witney

Oxon OX28 6JJ

Telephone: 01865 904303

bladderandbowelserviceadults@oxfordhealth.nhs.uk

**Please complete all sections of this referral form before sending it to the Bladder and Bowel Service. Incomplete forms will be returned resulting in a delay of the referral process.**

**Adult Community Bladder and Bowel Service Referral Form**

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| --- | --- | --- |
| **Surname:** |  | **Mr Mrs Miss Ms Other** |
| **NHS No** |  |
| **Forename(s)** |  | **DOB** |  |
| **Age** |  |
| **Address (including post code)** |  | **Tel No** |  |
| **Mobile** **Tel No** |  |
| **Email address:** |  |
| **Consent to contact via email yes/no** |  |
| **Key Code:** |  |  |  |
| **Next of kin and relationship to patient** |  | **Tel Nos** |  |
| **Best contact person (to arrange/remind of appointments):** |  | **Tel Nos** |  |
| **Doctors name and surgery****address** |  | **Tel Nos** |  |
| **Referrer name, address &** **profession/role if applicable)** | *We will be unable to process the referral if this section is incomplete* | **Tel No** |  |
| **Mobile No** |  |
| **Is the patient aware and has given consent to be referred to the Service?****Yes / No (delete as appropriate)** |
| *We will be unable to process the referral if this section is incomplete***Can the patient attend a clinic appointment? Yes / No (delete as appropriate)** |
| **Can the patient get onto an examination couch? Yes / No (delete as appropriate)** |
| **Clinics available at the following venues:** **Abingdon Banbury Bicester Chipping Norton Didcot Henley Oxford Wallingford Wantage Witney****If known, please delete any clinics that the patient would be unable to attend.** |

|  |
| --- |
| **Health Care Professional – for patients with bladder symptoms, please ensure a urinalysis has been performed before referral.** **What was the outcome/result?** |

**Reason for the referral: Bladder / Bowel (delete as appropriate)**

**Has the patient been referred to any other services for the same problem?**

 **Yes / No if yes, what service or department?**

**Brief medical history including relevant surgical history e.g. gynaecological or urological surgery or please write that you have given your consent for the service to access this electronically:**