

Choose and Book Referral
 Patient name:

NHS number:

Royal United Hospital Urogynaecology Continence Service

Please use this form together with your standard Choose and Book referral letter, which will contain practice details, patient demographics relevant medical history and medications. For reference purposes, please can you also complete the patient name and NHS number in the header above.

1. The Urogynaecology continence service is predominantly for women with symptoms of stress incontinence, urgency or urge incontinence. If the patient also has any of the following, please indicate and give details below :

- | | | | | | |
|--|--------------------------|---|--------------------------|---|--------------------------|
| Symptoms of a voiding difficulty | <input type="checkbox"/> | Continuous urinary leakage | <input type="checkbox"/> | Bladder pain | <input type="checkbox"/> |
| Previous continence surgery | <input type="checkbox"/> | Prolapse symptoms/signs with lower urinary tract symptoms | <input type="checkbox"/> | Neurological signs with lower urinary tract symptoms | <input type="checkbox"/> |
| Recurrent, proven lower urinary tract infections | <input type="checkbox"/> | Failed conservative management (3/12 supervised pelvic floor education via Continence Nurse or Women's Health Physiotherapy Team) | <input type="checkbox"/> | Other (only to be used in exceptional circumstances) | <input type="checkbox"/> |

Relevant details:

NB: Patients with Haematuria should be referred to the Urology Rapid Access Haematuria Clinic

2. If the patient only has stress incontinence, urgency, or urge incontinence:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Is the urinalysis/MSSU normal? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has a significant pelvic mass been excluded by abdominal and bi-manual examination? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Has any atrophic vaginitis been treated with 2/12 of topical oestrogens? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Has urinary diary been completed and polydypsia been excluded? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Has the woman been referred to the Continence Nurse / Women's Health Physiotherapy team for 3 months of conservative management? | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU HAVE ANSWERED NO TO ANY OF THE ABOVE, PLEASE CONSIDER IF REFERRAL IS APPROPRIATE AT THIS TIME. This form can also be used for referral to the Continence Nurse / Women's Health Physiotherapy team by faxing toIf conservative management is unsuccessful, the patient will be referred on automatically.

3. Please indicate any other relevant history:

4. Relevant current medication:

5. Other significant information:

BMI:

WEIGHT:

BP: