Western Health

Continence Service Referral Form

Phone: 8345 1355 **Fax:** 8345 4054
Email: continence@wh.org.au

Name:
.....
Date of Birth:
.....
Hospital UR# (if known):
.....

Fax referral to 8345 4054 or email to Continence@wh.org.au

For Clients residing in Wyndham	For Clients residing in Melton and Bacchus Marsh
Refer to HIPIntake@mercy.com.au	Refer to BM-intake@wh.org.au

Referrers details:

Referrers Name: ..... Position: .....Tel / Page .....

Referring Hospital / Agency / Clinic: ..... Unit: .....Ward:.....

Email:.....

Patient details:

Name: .....

Address: .....

Telephone: ..... DOB:_____/_____/_____

Reason for Referral/Patient Goal:

.....

.....

.....

.....

Requires:

☐ ISC Instruction ☐ Urodynamic Studies ☐ Nursing Continence Assessment ☐ Pelvic Floor Physiotherapy

☐ SWEP/CAPS Funding ☐ General Assessment

Relevant Medical/Surgical History: ☐ OR Health summary attached (for external referrers)

.....

.....

.....

.....

External referrers please attach previous investigations/information:

☐ Urine culture ☐ Renal tract ultrasound ☐ Abdominal X-Ray ☐ Other

☐ Bladder/Bowel diary ☐ Previous urodynamics ☐ Uroflow ☐ History of anticholinergic use.....

Care Package: ☐ Yes ☐ No Level .....

NDIS: ☐ Yes ☐ No

Does the patient require a home visit due to barriers attending in person: ☐ Yes ☐ No

Contact Person for Appointments: ..... Tel: .....

Relationship: ..... Mobile: .....

Interpreter Required: ☐ Yes ☐ No Language: .....