Enuresis Referral

PATIENT DETAILS *(To be completed by G.P.)*

Date Referral Received:	**Hospital Number:**
Surname:	**First Name:**
Address:	**Date of Birth:**
	Mother:
Telephone:	Father:
Sex: Male: ☐ Female: ☐	

1. Is the Enuresis primary (was 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 fears	Yes ☐	No ☐
I.	Faecal incontinence or soiling	Yes ☐	No ☐
3.	Is the child's growth normal?	Yes ☐	No ☐
4.	Are there significant emotional/medical problems? (If so please explain).		
5.	On examination:-		
(a)	Blood Pressure ☐		
(b)	Abdominal examination ☐		
(c)	Perineal examination ☐		
(d)	Examination of lower spine and lower limb neurology ☐		
6.	Results of Urinalysis or Urine Culture.		
7.	Has the child ever been seen by the Paediatric Service?	**Yes** ☐	**No** ☐
(a)	If you have answered Yes to any of these questions, please refer for Paediatric assessment.		
(b)	If you answered NO to all questions, please refer to Enuresis Clinic.		

Referring Doctors Name:	
Phone No.:	
Address:	

Please send referral to:- Enuresis Clinic, LOCAL DHB