Government of **Western Australia**
Child and Adolescent Health Service

CONFIDENTIAL – PATIENT INFORMATION

COMMUNITY HEALTH

NOCTURNAL ENURESIS REFERRAL FORM

Family name: .....

Given name: .....

UMRN: ..... DOB: .....

Sex (as on birth certificate):

☐ Male ☐ Female ☐ Indeterminate

Pronouns: (optional)

☐ He/him/his ☐ She/her/hers ☐ They/them/their

☐ Other .....

Address: .....

Parent/guardian surname: _____ Given name: _____

Mobile: _____ Email: _____

Interpreter required? ☐ Yes ☐ No Ethnicity: _____ Language: _____

Is the enuresis primary (i.e. never dry) or secondary in nature?

Details: _____

Are there other current comorbidities? ☐ Yes ☐ No

Details: _____

Has the young person already been reviewed and treated by a consultant? ☐ Yes ☐ No

Details: _____

If the young person has any of these symptoms they must be referred to a Consultant Paediatrician for review before they can be waitlisted with the Enuresis Clinic.

Are there any of the following features:

	Yes	No	Comments
• Day time wetting	☐	☐	_____
• Continuous dribbling	☐	☐	_____
• Poor urinary stream in male	☐	☐	_____
• Dysuria	☐	☐	_____
• Backache	☐	☐	_____
• Excessive thirst (waking at night to drink)	☐	☐	_____
• Recent onset of polyuria	☐	☐	_____
• Unexplained fevers	☐	☐	_____
• Constipation faecal incontinence or soiling	☐	☐	_____
• Urinary urgency or frequency	☐	☐	_____

On Examination

Please detail all clinical information below prior to sending this form.

- Blood pressure: _____ Results of urinalysis: _____
- Abdominal examination: _____
- Perineal examination: _____

Is the young person's growth within the normal range? ☐ Yes ☐ No

Does the child have any significant psychosocial problems? ☐ Yes ☐ No

Details: _____

Referring doctor's name: _____

Address: _____

Signature: _____ Date: _____

Upon completion please scan referral and email to CACH.Enuresisprogram@health.wa.gov.au

Do not write in margin

CHS150 NOCTURNAL ENURESIS REFERRAL FORM