



COMMUNITY HEALTH NOCTURNAL ENURESIS REFERRAL FORM	Surname: Given name: UMRN: Gender: DOB: Address:
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Parent/Carer 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Continuous dribbling	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Poor urinary stream in male	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Dysuria	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Backache	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Excessive thirst (waking at night to drink)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Recent onset of polyuria	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Unexplained fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Constipation faecal incontinence or soiling	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Urinary urgency or frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____

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