HSE Referral Form for
Community Continence Advisory Service (Level 2)

(This form is designed to be completed electronically. For writing, please expand the boxes that need more details before printing and ensure all print is in capital letters and legible)

Adult Referral ☐ Child Referral ☐

Client Name:	GMS/LTI No:
Address: Eircode:	DOB: Contact No:
Contact person if different to above - Name, address and phone number:	
Does the client need to be accompanied to appointment? Yes ☐ No ☐	
Client's Next of Kin:	Contact No:
GP name and address:	Contact No:
Referrer's name and title (print):	Email:
Signed (no signature required if emailed):	Phone:
Other relevant services involved (if you are referring a child, include name of school)	
Relevant Obstetric / Surgical / Medical / Social history:	
Adult urinary and bowel symptoms: *Please provide as much detail as possible (include with the referral any bladder/bowel record charts and/or relevant reports)*	
Child Urinary and bowel symptoms - Please tick if present: Toilet trained ☐ Daytime wetting ☐ Enuresis ☐ Constipation ☐ Faecal Soiling ☐	

Now please provide as much detail as possible (include with the referral any bladder and bowel record charts and/or relevant reports)	
Please describe the management plan already in place, including any treatment commenced or tried relating to this continence problem:	
Is the client in receipt of any continence products from the HSE? Yes ☐ No ☐	
Client aware of the referral Yes ☐ No ☐	Has the client consented to referral: Yes ☐ No ☐
FOR HSE OFFICE USE ONLY: The referral is accepted ☐ Estimated date of client assessment: / / Or The referral is not proceeding for the following reasons:	