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| **NCL Urinary catheter referral form – to be used for all adult patients transferred from secondary care into community care. NB all sections are mandatory** *Attach patient label*  |
| Name: | DOB: | Hospital no: | NHS no: |
| Address | Referring Dept: |
| Patient/carer Tel no: | Referrer name & contact no or email: |
| **Communication:** ❒ Hearing impaired – is signer required? ❒ Yes ❒ No ❒ Language……………………………. Interpreter required? ❒ Yes ❒ No |
| **Key discharge information:**Where is the patient being discharged to? ❒ Own home ❒ Sheltered accommodation ❒ Care home ❒ Nursing home ❒ Specialist supported housing Patient is ❒ Housebound ❒ Non-housebound |
| **Reason for referral:**❒ Long-term catheter management❒ Trial without catheter (TWOC)❒ TWOC with Intermittent self-catheterisation (ISC)❒ TWOC with Intermittent self-dilatation (ISD) ❒ Continue ISC❒ Continue ISD | **Reason for catheterisation**❒ Acute urinary retention - post void residual volume ….…ml ❒ Chronic urinary retention - post void residual volume …....ml ❒ Post operative❒ Urinary incontinence ❒ Other (give details) …………………………………………………. |
| **Essential catheter information:** Date catheter inserted: …………………………… Next catheter change due by (specify date):………………………..…Please confirm this patient has the NCL catheter passport: ❒ Yes ❒ No – reason…………………………………. **Catheter type:** **Catheter *in situ* for:** **Catheter size:** ❒ 10 ❒ 12 ❒ 14 ❒ 16 ❒ 18 ❒ Suprapubic ❒ Medium term (4 weeks) ❒ Urethral ❒ Long Term (12 weeks) Drainage: ❒ Long tube bag ❒ Short tube bag ❒ other (specify)………………………... ❒ Valve   |  |
| Any complications with catheterisation? ❒ No ❒ Yes (give details)…………………………………………….Does the catheter need to be changed/replaced in secondary care? ❒ Yes ❒ No |
| Hospital discharge summary attached? ❒ Yes ❒ No - please attach clinical history  |  |
| Allergies? ❒ No ❒ Yes – give details |  |
| Dementia/Alzheimer’s? ❒ Yes ❒ No Learning disabilities? ❒ Yes ❒ No Does the patient have capacity to make decisions in relation to catheter care? ❒ Yes ❒ No  | Visually impaired? ❒ Yes ❒ NoOther? ❒ Yes (give details)……………………… ❒ No |  |
| **Other relevant information:**Infection status: ❒ MRSA ❒ *C. diff* ❒ Covid-19 ❒ other (give details)……………………………….Any safeguarding concerns? ❒ Yes (give details)……………………………… ❒ No Is patient bedbound/wheelchair user? ❒ Yes (give details)………………………………………………………… ❒ No Carers/package of care in place? ❒ Yes (give details)…………………………………………………….. ❒ No Keysafe? ❒ Yes (give number)……………......... ❒ No |  |
| 1 week home pack provided? ❒ Yes ❒ No - if no, state why not……………………………………. Has the patient been registered for home delivery? ❒ Yes (state which company):……………………………………………  ❒ No - if no, state why not……………………………………. |
| **Please note referrals will be rejected if incomplete or discharge summary/clinical history not provided** |
| **District Nursing Services:** **Barnet:** clcht.plannedcarebarnet@nhs.net - **Tel:** **0300 020 0655** **Camden:** camdenreferrals.cnwl@nhs.net - **Tel:** **020 3317 3400****Haringey:** haringey.adult-referrals@nhs.net - **Te**l**: 020 3316 1600 / 24 hrs - 020 7288 3555****Islington:** rapidaccess@islington.gov.uk  **- Tel: 0207 527 2179****Enfield**: beh-tr.ECSenfieldlocalityteamsSPA@nhs.net **– see below:****Monday – Friday** **08.00 – 16.30hrs** District Nursing Office: - **Tel: 020 8702 5910** **16.30 – 08.00hrs** Royal Free Hospital, ask for District Nursing Service: **Tel: 020 7794 0500** **Weekend & Bank Holidays** (24hr service) Royal Free Hospital, ask for District Nursing Service: **Tel: 020 7794 0500** |