



# CHILDREN'S BEDWETTING REFERRAL FORM



Department of Health

Osborne Park Hospital

## PATIENT DETAILS

**Surname:**

First name:

**Next of Kin** (name & relationship)

**Mother's Surname** (if different to above & not mentioned in next of kin details):

Address:

Telephone:

Postcode:

Birthdate:

**Sex:** M / F

- 1 Is the enuresis  Primary (never dry)  
 Secondary (previously dry)
- 2 Is the following present (please tick if present)?
- Daytime wetting
  - Continuous dribbling
  - Poor urinary stream in male
  - Dysuria
  - Backache
  - Excessive thirst (waking to drink at night)
  - Recent onset polyuria
  - Explained fevers
  - Faecal incontinence or soiling
- 3 Is growth normal?  Yes  No
- 4 Are there associated significant emotional/medical problems? Please outline if relevant:  
 Yes  No
- 5 Examination (please summarise finding if relevant):
- |                       |                                 |                                   |
|-----------------------|---------------------------------|-----------------------------------|
| Blood pressure        | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Abdominal examination | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Perineal examination  | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
- 6 Urinalysis (please summarise finding if relevant):  
 Normal  Abnormal
- 7 Interpreter needed?  Yes  No Language:

## REFERRING DOCTOR

**Name:**

**Signature:**

**Address:**

**Telephone:**

**Fax:**