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

Perth Children's Hospital

Nocturnal Enuresis (bedwetting) clinical referral form

Patient details

Surname:_____ First name: _____

Address: _____

_____ Postcode: _____

Birth date (DD/MM/YYYY) _____ Sex: Male / Female Phone:_____

Next of kin: _____

Email: _____

1. Is the enuresis primary (i.e. never dry) or secondary in nature? **Yes / No**

2. Are there any of the following features?
   a. Day time wetting and/or frequency and/or urgency **Yes / No**
   b. Continuous dribbling **Yes / No**
   c. Poor urinary stream in male **Yes / No**
   d. Dysuria (painful or difficult urination) **Yes / No**
   e. Backache **Yes / No**
   f. Excessive thirst (waking at night to drink) **Yes / No**
   g. Recent onset of polyuria **Yes / No**
   h. Unexplained fever **Yes / No**
   i. Constipation, faecal incontinence or soiling **Yes / No**

If the child has any of these symptoms, then they must be referred to a Consultant Paediatrician for review before they can be waitlisted and offered treatment with the Continence/Enuresis Service.

Child reviewed and treated by Consultant? **Yes / No**

3. Is the child's growth normal? Height:____ Weight: ____ **Yes / No**

4. Are there associated significant emotional/medical problems?
   _____

5. On examination:
   a. Blood pressure _____
   b. Abdominal pressure _____
   c. Perineal examination _____

6. Results of urinalysis or urine culture: _____

7. Interpreter required: **Yes / No** Language: _____

8. Does this child have features that concern you which require the assessment of a Consultant Paediatrician at PCH?

   Yes / No

9. If the reply to question 8 is **no**, the child will be referred directly to the Enuresis Clinic Nurse.

Referring Doctor's name: _____

Address: _____

_____

Date: (DD/MM/YYYY) _____ Signature: _____

Return to Central Referral Service: P 1300 365 056, F 1300 365 056 or online

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Locked Bag 2010, Nedlands WA 6909

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