

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are there any of the following features?
3. Day time wetting and/or frequency and/or urgency **Yes / No**
4. Continuous dribbling **Yes / No**
5. Poor urinary stream in male **Yes / No**
6. Dysuria (painful or difficult urination) **Yes / No**
7. Backache **Yes / No**
8. Excessive thirst (waking at night to drink) **Yes / No**
9. Recent onset of polyuria **Yes / No**
10. Unexplained fever **Yes / No**
11. Constipation, faecal incontinence or soiling **Yes / No**

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

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

1. Is the child’s growth normal? Height: Weight: **Yes / No**
2. Are there associated significant emotional/medical problems?
3. On examination: **a)** Blood pressure \_\_\_\_\_\_\_\_

 **b)** Abdominal pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **c)** Perineal examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Results of urinalysis or urine culture:
2. Interpreter required: **Yes / No** Language:
3. Does this child have features that concern you which require the assessment of a Consultant Paediatrician at PCH?

# Yes / No

1. 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:

15 Hospital Avenue, Nedlands Fax: 6456 0097



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