Child and Adolescent Health Service

PRINCESS MARGARET HOSPITAL FOR CHILDREN
NOCTURNAL ENURESIS (BEDWETTING) CLINIC REFERRAL FORM
PH: 9340 8356 Fax: 9340 8733 Email: pmh.enuresiscontinence@health.wa.gov.au

PATIENT DETAILS

Surname: _____ First Name:_____

Address: _____

_____ Postcode: _____

Birth date: ___ / ___ / ____ Sex: Male / Female Phone: _____

Next of Kin: _____

1 Is the enuresis primary (ie. never dry) or secondary in nature?

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**	**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 fevers**	**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 Enuresis Clinic.

Child already reviewed and treated by Consultant yes no

3 Is the child's growth normal? Ht: Wt: yes no

4 Are there associated significant emotional / medical problems?
_____

5 On examination:
- **a. blood pressure**
- **b. abdominal examination**
- **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 PMH? Yes / No

9 If the reply to Question 8 is NO, the child will be referred directly to the Enuresis Clinic Nurse

Referring Doctors Name: _____

Address: _____

_____

Date: ___ / ___ / _____ Signature:
_____