Nurse Urology Unit Referral Form

This form should only be completed by a Clinician.

Patient's Full Name:		CHI Number:	
Gender:		Referring Clinician:	
Date of Birth:		Date of Referral:	

Tick the box for the required referral and complete the information requested.

Trial without catheter

Required in weeks

Reason for catheterisation Residual

Catheter size Date inserted H20 in balloon

DRE (if performed)

Relevant Medication ?anti-coagulant Other relevant

Is patient constipated Consider laxatives

Does patient have a UTI Consider antibiotics

Known BPH Consider alpha blocker and or 5ARI

Treatment initiated

Relevant medical/social information/cognitive impairment

Catheter change (First change SP by DN in community, except Forth Valley)

Catheter type:

Reason for change in nurse urology

Size of catheter

Cystogram and trial without catheter

Cystogram requested Cystogram date (if known)

Intermittent Self Catheterisation

New If taught on ward:

Review Size of catheter:

Catheter removal first

Flow and Residuals

When?

Reason

TURP/Green Light Laser phone follow up in 12 weeks

Type:

Date of Surgery:

Completed By:		Date:	

Submit