Continence Nurses Australia
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Referral Form – To Continence Nurses Australia

Client Details **Referral Date: / /**

Clients full name: _____

Gender: Male ❒ Female ❒ Other ❒ **D.O.B:** _____

Address: _____

Postcode: _____ **State:** _____

Preferred Phone Number:

Participant Email:

Country of birth: Do you identify as ATSI? ❒ Yes ❒ No

Interpreter required ❒ No ❒ Yes, Language:

Next of kin details

Name: Phone:

Relationship: Email:

GP details

Name: Phone: Email:

Name Person / Agency referring Self-referring ❒ Yes ❒ No

Name of referrer: _____

Name of organisation: _____

Phone: _____ Email: _____

Disability, medical and surgical history: Please attach a patient summary.

Bladder and / or bowel problem: Please describe the main problem/s below.

Bladder:

Bowel:

Other:

Medications: Please include all prescribed and over-the-counter medications and vitamins.

Please attach a patient summary if you have one.

Reason for referral

Please note that a continence assessment, written prescription, and report may take 4 – 6 hours to complete.

❒ Initial continence assessment – private client
❒ Home care package client continence assessment
❒ NDIS continence assessment ❒ Ongoing review, support, or training
❒ Catheter management ❒ Bowel management program
❒ Other:

Payment and/or funding of service Please note this service is fee for service

❒ Self-funded ❒ Funding through Aged Care Provider: _____
❒ Other HCP Funding Level: ❒ 1 ❒ 2 ❒3 ❒ 4

❒ **Funded through NDIS:** Number:_____ ❒ Self-Managed *or*
❒ Plan Manager Email: _____
Funding Budget ❒ Core Budget ❒ Capacity Building budget
❒ NDIA Managed ****Unable to see NDIS Managed referrals***

Please send referrals to sue@continencenurses.com **Referral received: ___ / ___ / ___**