

Referral Criteria for SEHSCT Paediatric Specialist Continence Service

General Referral Criteria

The paediatric continence nurse advisor will assess treat and support children and young people aged 4- 18 years who have specialist continence needs and who are living within the boundaries of the SEHSCT

Children and young people up to age 19 with global developmental delay, neurological or developmental anomalies who have not responded to first level continence management can also be referred

General Exclusion Criteria

- Young people aged 18 or over (19 if they have additional needs)
- Children and young people living outside the boundaries of SEHSCT
- Children and young people who have not received initial assessment support and intervention from referrer
- “Red flag “symptoms as outlined in condition specific criteria

Daytime Wetting Referral Criteria

- Children aged five and over with daytime wetting who have not responded to appropriate management from referrer (This does not include delayed toilet training)
- Bladder storage problems e.g. overactive bladder
- Bladder emptying problems e.g. dysfunctional voiding, UTI’s

Daytime Wetting Exclusion Criteria

- History of repeated febrile UTI’s
- Child (particularly girls) reported to have continuous dribbling/ wetting
- Reported straining to void/ weak stream

These are red flag symptoms and require referral to a paediatrician for further investigation to rule out organic causes

- Children requiring catheter care

Please continue to refer these children to the RBHSC

Nocturnal Enuresis Referral Criteria

Children and young people aged 6 or over with night time wetting and who have had no response to initial intervention of a minimum of 16 weeks

Nocturnal Enuresis Exclusion Criteria

- Recent systemic illness causing secondary enuresis
- History of reported weight loss/ excessive thirst

These are red flag symptoms and require referral to paediatrician for further investigation to rule out organic causes

Idiopathic Constipation Referral Criteria

- Children with a history of constipation for a period of 8 weeks or longer and who have no known anatomical or physiological abnormality
- Children aged four and over with soiling or severe constipation who have not responded to appropriate management from referrer

Idiopathic Constipation Exclusion Criteria

- Children with faltering growth
- Children with a past history of delay of longer than 48hours in passing meconium
- Children with a history of passing “ribbon stools “since birth
- Concern re: gross abdominal distension with vomiting
- Recent reported weakness in legs
- Abnormal appearance of anus
- Abnormality of lumbosacral/ gluteal regions e.g. sacral dimple

These are red flag symptoms and require referral to paediatrician for further investigation to exclude organic causes

- Children requiring rectal irrigation
- Children requiring stoma care

Please continue to refer these children to RBHSC

Paediatric Specialist Continence Service Referral form

Childs Name		DOB	
Address		Gender	
H&C Number		Ethnicity	
Language Spoken		Interpreter Required	Y / N
GP Name		GP Address	
School/Playgroup		School nurse Name	
Disability or Additional Needs, Please Specify details of any additional needs:	Y/N	Any allergies or adverse reactions:	

Referrer Name		Date of Referral	
Job Title		Email address	
Contact number		Address	

Person with Parental Responsibility

Name		Relationship	
Tele No.		Email	
Parental consent:	Y/N	Address:	
Other Contact		Relationship	

Telephone No.			
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Other Professionals Involved with Child & Family (include name and contact details)

Health Visitor		CAMHS	
Paediatrician		AHP's	
Known to social service	Y / N	Social Worker	
Child on CPR	Y / N	SW Contact No.	
Parent/Child aware of referral	Y / N	Consent Obtained	Y / N

PLEASE SEND ANY OTHER RELEVANT DOCUMENTATION WITH REFERRAL FORM BY EMAIL TO:-

Paediatric.ContinenceService@setrust.hscni.net

OR POST TO :-

Paediatric Continence Service, Scrabo Children's Centre , Ards Hospital BT23 4AS

Reason for Referral (please tick appropriate box/ boxes)

Constipation		Faecal Soiling		Day time wetting		Night time wetting	
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Height	Weight	Date recorded
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Findings on physical examination	Date
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Outline Continence concerns, strategies already completed and treatments in place:
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Past Medical History and Diagnosis:

Please list current prescribed/ non prescribed medications taken including name, dose and frequency

Date and Signature: