CONTINENCE NURSES AUSTRALIA

Continence Nurses Australia
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Referral Form – Continence Nurses Australia

Client Details	**Date: / /**
Clients full name:	
Address: State:	Postcode:
D.O.B:	Country of birth:
Do you identify as Aboriginal and Torres Strait Islander? ❒ Yes ❒ No	
Interpreter required ❒ No ❒ Yes, Language:	
Preferred Phone Number:	Email:
Next of kin details	
Name:	Phone:
Relationship:	E mail:
GP details	
Name: Address: Phone:	Postcode: Email:
Name Person / Agency referring	Self-referring ❒ Yes ❒ No
Name of referrer: Phone:	Name of organisation: Email:
Medical and surgical history:	
Bladder and / or bowel problem Please describe main problem/s below	
Bladder:	
Bowel:	
Other:	
Medications Please include all prescribed and over the counter medication	
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 ❒ My Aged Care – Home care client continence assessment ❒ NDIS continence assessment ❒ Ongoing review, support, or training ❒ Catheter management ❒ Uridome management ❒ Other:	
Payment and/or funding of service **Please note this service is fee for service**	
❒ Self-funded ❒ Funding through Aged Care Provider ❒ Funding through DVA ❒ Funding through TAC ❒ Other	
❒ **Funded through NDIS** ❒ NDIA Managed *or* ❒ Self-Managed *or* ❒ Plan Managed by: ❒ **NDIS #:**	

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