**SHAPMS Appliance Prescription Service Referral Form - Urology**

**Please email completed referral to:** [**prescriptionservice.bhg@nhs.net**](mailto:prescriptionservice.bhg@nhs.net)

**NOT TO BE USED FOR REFERRAL FOR CONTINENCE PADS**

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| --- | --- | --- | --- | --- | --- | --- |
| **Surname:** |  | | **DOB:** | | |  |
| **Forename(s):** |  | | **NHS No:** | | |  |
| **Address:**  **Post Code:**  **Tel No:**  **NOK contact (if applicable):** | | | **GP Practice:**  **Tel No:** | | | |
| **Relevant Medical/Surgical History:** | | | | | | |
| **Urology Management (including reason for catheterisation):**  **ISC patients – How many catheters PER day needed?** | | | | | | |
| **Are valves contraindication due to high pressure urinary retention?**  **Yes No** | | | | | | |
| **What products are required? Please tick below:**  **Long tube leg bag Night drainage bags**  **Short tube leg bag Catheter retaining strap**  **Catheter Lubricant**  **Catheter valve**    **Catheter Packs Catheter Sleeve**    **Catheter please stipulate size and female or standard length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ISC – Please State Product Code(s) -**  **Other e.g. Sheath** | | | | | | |
| **Referred By (Please Print):** | |  | | **Job Title:** |  | |
| **Date:** | | **Telephone Number:** | | | | |
| **The service operates 9am – 5.30pm Mon – Fri (excluding Bank Holidays).**  **Referrals outside of these hours will be processed the next working day.**  **Any queries please ring 0800 138 8311** | | | | | | |