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

**Please email completed referral to:** **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** |