

**LUTS Clinic Referral Form**

Please ensure that ALL the patient details are completed:

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| **Patient Name:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Patient Address:** |  |
| **NHS Number:** |  |
| **GP Name** |  |
| **GP Surgery Name & Address:** |  |
| **GP telephone number:** |  |
| **CCG of residence:** |  |

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| **Referrer** | | | |
| **Referrer Name & Role:** |  | | |
| **Referrer Work Address:** |  | | |
| **Referrer Telephone no:** |  | **Date of referral** |  |

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|  | **Criteria** | **Tick if ‘Yes** |
| 1 | This is a secondary care referral. |  |
| 2 | Patient is over 18 year old |  |
| 3 | Patient presents with chronic lower urinary tract symptoms (CLUTS) presumed to be chronic or recurrent infection as per PHE Diagnosis of UTI reference guide:   1. 3 or more presumed episodes of urinary infection diagnosed or inferred by the referrer **in a year**; or 2. 2 or more episodes of presumed urinary infection diagnosed or inferred by the referrer **within the last 6 months**. |  |
| 4 | Patient has been investigated and managed in a secondary care setting  AND has failed to respond to all standard treatment for lower recurrent UTI under established guidelines (including NICE and EAU guidelines). |  |
| 5 | All the following has been provided with this referral form:  History of recurrent infections AND detailed history of previous investigations & treatments.  Copy of USS imaging of the renal tract.  GPs summary of the patient’s medical history |  |
| 6 | Patient does **not** have lower urinary tract cancer. |  |
| 7 | Patient and their GP have been informed of the use of off-license treatments outside of national guidelines by the LUTS clinic |  |
| 8 | The LUTS clinic patient’s guide leaflet has been provided to the patient |  |

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| **Details** |
| **Presenting complaint:** |
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| **History relating to presenting complaint:** |
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| **Detailed history of treatments that have been tried including doses, duration and outcome**: |
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| **Results of investigations (details of where the investigations were undertaken and dates must be provided) - *copies of imaging must be provided as an attachment*:** |
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| **Psychosocial and or psychosexual history (e.g. emotional, physical, psychological, sexual, social issues):** |
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| **Any other medical history?** |
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| **Allergies and intolerances – *please provide details of the types of reaction*:** |
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| **List of current medications:** |
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