|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TITLE |  | FORENAME |  | SURNAME |  |
| DELIVERY ADDRESS (INC POSTCODE) |  | NHS NUMBER |  |
| DATE OF BIRTH |  | CONTACT No. |  | GP PRACTICE |  |
| Nursing Care |  | Residential Care |  | CHC Funded |  |

Hip/waist measurement in cm, this is essential if you are requesting washable pants, slip style pads or pull ups. Contact the Continence Service for Authorisation

|  |  |
| --- | --- |
|  | cm |
|  |  |

 if applicable, in CMs

|  |  |  |  |
| --- | --- | --- | --- |
| **CODE** | **PRODUCT DESCRIPTION** | **Working** **Absorbency per pad** | **QTY per 24hrs** |
|  Have you considered Washable products and other alternatives to disposable products first?For more information on alternative products and the Washable product formulary then access the NHS staff zone. |  |
| Washable Products – please add size/absorbency/code to the additional information box |
| **Faecal – DO NOT use for urinary incontinence** |  |
| CFP1732H | Anatomical Pad | N/A |  |
| **Small Shaped Pads – Light Urinary Incontinence** |  |
| CFP1745H | iD expert light Maxi | 250-350mls |  |
| **Large shaped Pads** |  |
| CFQ922H | iD Expert Form Normal | Up to 500mls |  |
| CFP85081 | Lille Suprem form Regular Plus | 500-625mls |  |
| CFP2193 | iD Expert Form Extra | 625-700mls |  |
| CFP85082 | Lille Suprem form Extra Plus | 700-1000mls |  |
| **Disposable Bed Sheets for Bowel Care ONLY** |  |
| VMU022H | Attends Cover-Dri 60x60 Plus | N/A |  |

|  |
| --- |
| **CLINICAL INFORMATION** |
| Urinary Incontinence |  |
| Faecal Incontinence |  |
| Poor Mobility |  |
| Nursed in bed |  |
| Dementia/Alzheimer’s |  |
| Learning Disability |  |
| Elderly / E.M.I |  |
| Mental Health Illness |  |
| Diabetes |  |
| Urological Condition |  |
| On diuretics (Dose) |  |
| Neurological Disorder |  |
| CVA / Stroke |  |
| Additional Clinical Information:

|  |
| --- |
| **BLADDER DIARY RESULTS** |
| Ave. daily intake (mls) |  |
| Voiding frequency in 24hrs |  |

 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of clinician completing form - PRINT** |  | **Designation/Role** |  |
| **Signature of Clinician Completing Form** |  | **Email Address** |  |
| **Date Assessment Completed** |  | **Mobile Number** |  |
| URGENT DELIVERY |  | REASON FOR URGENT DELIVERY REQUEST |  |