

UROLOGY ONE STOP CONSULT Non-Visible (Microscopic) Haematuria & UTI Referral Form

Please tick to indicate which treatment centre you are referring your patient to and fax this completed and signed form to the fax number indicated below:

Emersons Green NHS Treatment Centre (fax. 0117 906 1950)

REFERRER DETAILS	PATIENT DETAILS
Date of referral <input type="text"/>	Name <input type="text" value="(Title, Forename, Surname)"/>
Referring GP <input type="text"/>	Address <input type="text"/>
Practice name <input type="text"/>	<input type="text"/>
GP no <input type="text"/>	<input type="text"/> Postcode <input type="text"/>
GP practice <input type="text"/>	Telephone <input type="text"/>
PCT name <input type="text"/>	Mobile <input type="text"/>
Practice address <input type="text"/>	Date of birth <input type="text"/> NHS no <input type="text"/>
<input type="text"/>	Gender <input type="text"/> Ethnicity <input type="text"/>
Telephone <input type="text"/>	Height <input type="text"/> Weight <input type="text"/>
Fax <input type="text"/>	Transport required <input type="checkbox"/> Yes <input type="checkbox"/> No
Email address <input type="text"/>	Transport requirements <input type="text"/>
<i>Please complete if not the patient's regular GP</i>	<input type="text"/>
Name of patient's GP <input type="text"/>	Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of GP practice <input type="text"/>	Interpreter requirements <input type="text"/>
	<input type="text"/>

This service is not for visible (macroscopic haematuria). These should be referred to the local DGH under the 2 Week Wait rule

INDICATION - Micro-haematuria

(please tick - all three must be appropriate)

- True microscopic haematuria (Dipstick+ve -1+ or more, not trace, whether haemolysed or not, unrelated to menstruation, UTI, colouring from drugs, dyes, foodstuffs)
- Persistent microscopic haematuria (≥ 2 out of 3 occasions)
- Symptomatic microscopic haematuria aged 18yrs or more
OR
Non-symptomatic microscopic haematuria aged ≥ 40 yrs or more

Please perform these two pre-referral tests - results to accompany referral please:

- Serum U&Es
- Urine Protein/creatinine ratio- on a random single specimen of urine if $\geq 1+$ proteinuria on dipstick

ADDITIONAL INFORMATION

We would aim to see your patient within an integrated unit with most patients discharged the same day with documentation to them and yourself confirming results of investigations and possible conclusion of episode of care.

Referrer signature Date