Referral for Urodynamics / Uroflow Test

Good People MEDICAL CENTRE

Service Requested: **[ ] Urodynamics Test** **[ ] Uroflow Test**	
Date of Referral:	
Referrer's name and title (print):	Email:
Client Name (print):	
Address:	DOB:
Eircode:	Contact No:
Does the client need to be accompanied to the appointment?	[ ] Yes [ ] No
Does the client need an interpreter?	[ ] Yes [ ] No
Client's next of kin	Contact No:
GP name and address:	Contact No:

Reason for referral and presenting symptoms (tick all that apply):

[ ] Urinary Urgency [ ] Urge Incontinence [ ] Stress Incontinence

[ ] Urinary Frequency [ ] Incomplete bladder emptyin [ ] Slow/Weak urine stream

[ ] Hesitancy/difficulty initiating void

Other please specify:

Previous Bladder treatment/Investigations:

Obstetric History:

Medical History:

Surgical History:

Current Medications:

Known allergies:

Additional Information:

Referring Clinician's signature:	Date: