



REFERRAL FOR CONSTIPATION MANAGEMENT

Residential Care Line

Date of referral:	Facility:	Referral source:
Resident name:	DOB:	
GP Name:	GP aware of referral: ☐ YES ☐ NO	
GP Number:		
AHD / ACP / GoC: ☐ YES ☐ NO	Date completed:	
CNM name:		
CNM aware of referral: ☐ YES ☐ NO		
Name of referrer:		

History (click relevant)	
Patients' Mobility: ☐ Independent ☐ Supervision ☐ Assisted ☐ Chair-bound ☐ Bed-bound	
Fluid intake/day:	
History of Constipation: ☐ YES ☐ NO	
Recent changes in health? ☐ YES ☐ NO	Details:
Recent Falls? ☐ YES ☐ NO	Details:
Any recent change in medications (analgesia and or psychotropics): ☐ YES ☐ NO	
Details:	
Any recent or last x-ray/CT scans: ☐ YES ☐ NO	
If Yes, please attach to referral.	
Any recent ED presentations related to Constipation: ☐ YES ☐ NO	
If Yes, please attach last discharge summary	
Abdominal assessment (all quadrants)	
Palpation: ☐ Soft ☐ Firm	Inspection: ☐ Normal ☐ Distended
Bowel Sounds: ☐ YES ☐ NO	Percussion: ☐ Dull ☐ Resonant
Pain & location:	Is there palpable stool (PR exam): ☐ YES ☐ NO
Last voided:	Is there possible urinary retention: ☐ YES ☐ NO

Documents required (Please attach to reply)			
Medication Profile	Medical History	Bowel Chart – 5–10 days	Fluid intake chart – Minimum 5 days

