BOWEL INCONTINENCE
REFERAL FORM

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

INSTITUTE FOR DIGESTIVE SURGERY

1. Patient Information			
Referral Date			
Name			
Phone		Gender	❑ MALE ❑ FEMALE
Date of Birth	MM/DD/YYYY	Patient ID	
2. Diagnosis			
❑ Full incontinence of feces (R15.9)			
❑ Other			
3. Symptoms			
Episodes/day or week			
Length of Symptoms			
Anal Sphincter Status (% intact)			
Female only: Symptoms persist >12 mo. after vaginal delivery			❑ YES ❑ NO
Not related to neurological condition, anorectal malformation, or chronic IBD			❑ YES ❑ NO
4. Medications			
❑ Loperamide ❑ Lomotil ❑ Cholestyramine ❑ Tricyclic Anti-depressants ❑ Opiates			
❑ Other			
5. Conservative Therapies			
❑ Absorbent Pads ❑ Diet Modification ❑ Antegrade Cleansing Enemas (ACE)			
❑ Behavioral therapy (Biofeedback) ❑ Pelvic muscle exercises ❑ Anal Plugs			
❑ Other			
6. Results			
7. Quality of Life			
Do symptoms affect the patients Quality of Life? (If yes, explain)			❑ YES ❑ NO
8. Voiding Diary Results			
Episodes/day or week			
Test Stimulation Results			
% Improvement in Symptoms			
Comments			
9. Physician			
Name (PRINT)		Phone	
Date			
Signature			

PLEASE FAX TO (208) 415-0150

THANK YOU FOR YOUR REFERRALS.

Need More Forms?

HOW TO ORDER

CALL
(208) 262-0945

FAX
(208) 415-0150

EMAIL
nwsh.digestive@nwsh.com

VISIT
nwsh.com/referrals

MAIL
750 N. Syringa Street, Suite 205
Post Falls, ID 83854

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