MANAGEMENT AND TREATMENT OPTIONS (One or more options may be chosen)		
Pelvic Floor Exercises	Bladder Retraining	Toileting Programme
Medication	ISC	Bowel Control
PADS	Nursing Aids (specify)	Sheath Appliance
SPECIFY CARE PATHWAY USED:		
If pathway not used state reason why:		

IF PADS REQUIRED, SPECIFY TYPE	
DAILY REQUIREMENT AS PRESCRIBED BY ASSESSOR	
DAYTIME	NIGHT TIME
AMOUNT	AMOUNT
NET PANTS SIZE	

REFERRAL TO OTHER DISCIPLINE	
GP Hospital Consultant	Physiotherapist
District Nurse	Other

Yearly review to identify any change medical history, symptoms, intake / output, steps taken to improve quality of life and outcome.

CONTINUATION SHEET	Date	Signed

Northern Health and Social Care Trust

N/AS/CN3

CONTINENCE ASSESSMENT FORM

Date of Referral:	
Referred by:	
Date of First Assessment:	
Date of Discharge:	Outcome:

Name: DOB:

Address:

Post Code:

Telephone: Work / Mobile:

Assessed by: Caseload Holder:

GP H&C Number:

Outline of Problems Affecting Patient (Physically, Socially and Psychologically)

Medical History	Surgical History	Obstetric History		
		Parity:		
		Difficult Delivery:	Yes	No
		Baby Weight:		
		Caesarian	Yes	No

Medication	Family History of Diabetes?
	Known Allergies?

Smoker / Non Smoker:	Weight:	Duration of Problems:
	Recent Weight Loss:	

COMMUNICATION DIFFICULTIES	
i.e. Memory/eyesight/hearing/psycholgical: Yes / No	
Comments:	
Normal sleep pattern:	
MOBILITY / DEXTERITY	
Full:	Assisted:
Use of Aid:	Immobile:
Type of Aid:	
ENVIRONMENTAL DIFFICULTIES	
Are all facilities accessible:	Are all care requirements available:
If not, action taken:	

ASSESSMENT OF BLADDER SYMPTOMS

SYMPTOMS OF URGE INCONTINENCE		
When you feel the need to pass urine, how long can you wait?		
Does anything trigger the need to pass urine? e.g. running water		
Do you sometimes leak before you reach the toilet?	Yes	No
Do you visit the toilet frequently?	Yes	No
Do you need to pass urine during the night?	Yes	No
If yes, how often?		
Do you ever wet the bed?	Yes	No
Do you feel the urgent need to void when you put the key in the front door?	Yes	No
Do you feel the urgent need to void when you go out in cold weather?	Yes	No

SYMPTOMS OF STRESS INCONTINENCE		
Do you leak when you cough, laugh, sneeze or exercise?	Yes	No
Are you able to stop midstream?	Yes	No
Do you leak when you get out of bed?	Yes	No

SYMPTOMS OF OVERFLOW INCONTINENCE		
Do you have to strain to empty your bladder?	Yes	No
Have you noticed any change in your stream of urine?	Yes	No
Do you have a problem initiating the flow?	Yes	No
After passing urine, does your bladder still feel full?	Yes	No
Are you wet/damp most of the time?	Yes	No
Are you aware of urine leaking?	Yes	No
Do you ever leak immediately after passing urine?		

SYMPTOMS OF REFLEX INCONTINENCE		
Are you aware of the need to pass urine?	Yes	No
Does your bladder ever empty without warning?	Yes	No

VOIDING SYMPTOMS	FREQUENCY / VOLUME CHART
Dysuria:	Average daily intake of fluids mls
Haematuria:	Average ouput mls
Does your urine smell:	Day frequency no:
INVESTIGATIONS:	Night frequency no:
	Are fluids restricted:
	Type of fluids:
Urinalysis:	
MSSU sent: Date:	
Results:	

RELEVANT INVESTIGATIONS: _____

BOWEL HISTORY AND ASSOCIATED PROBLEMS

Length of time of problems:	Consistency of Motion:	
Normal Habit:	Associated Smell:	
Recent changes in bowel habit:	H/O Soiling:	H/O Urgency:
Problems affecting bowel control:	H/O Constipation:	H/O Self help:
	Laxative use:	
	Constant or intermittent problem:	
	Bowel awareness & need to void/sensation intact:	
DIET:	Associated Pain/Discomfort/Bleeding:	
	Would anxiety affect bowel control:	
	Is desire to have motion accompanied by sweating / palpitations?	
Dietary advice given?	Flatus Incontinence?	

CLINICAL EXAMINATION:	RECTAL EXAMINATION:		
Leakage on Cough at examination:	Sphincter: Lax / Descending / Strong	Yes	No
Prolapse: Cytocele / Uterine / Rectocele	Constipated / Impacted / Haemorrhoids		
Vaginal Discharge:			

PELVIC FLOOR ASSESSMENT:

	No Movement 0	Flicker – 1	Weak – 2	Moderate – 3	Good – 4	Strong – 5
Perineal skin healthy If no specify:						
General skin integrity: Problematic: Not problematic:						

Residual Urine Suspected: Yes ☐ No ☐

Residual Urine Amount: Date

Date	Power	Endurance	Repetition	Fast Squeezes

RESULTS OF ASSESSMENT:

Types of Incontinence:	Faecal		
	Stress	Urge	Mixed
	Functional	Reflex	Overflow

Problems Identified:

Signed: _____ Date: _____

Senior Nurse Signature: _____ Date: _____