Northern Health and Social Care Trust

H/AS/CN6

REVIEW OF URINARY INCONTINENCE

Name:	D.O.B.
Address: Post Code: Tel Number:	G.P. GP Base: Practice Code: GP Contact Number:
Review carried out by: __________________ Designation: __________________	Date of last assessment: __________________ Date of this assessment: __________________
Caseload Holder: __________________ Contact Number: __________________	Base: __________________

Update of known Medical Conditions

(If the Health Care assistant is carrying out this review, the nurse should complete update of known conditions)

Are there any new conditions since last review? ____________________________

Are there any changes of medical condition since last review? ____________________

Any changes in medication since last review? ____________________________

____

Urinalysis results? (either note results or add print out from urinalysis machine) ____________

____

Was an M.S.S.U. sent for lab analysis?______________________________

Fluid intake per day (cups/per day) ______________________________

Fluid output per day (visits to toilet/day) ____________________________

Type of fluids (tea/coffee etc)________________________________

Is patient independent / or dependent on carers____________________________

PROVISION OF PADS

What pads per 24 hours are currently ordered for this patient? Daytime: ____________________
Night time: ____________________

How many pads are used each day/night? Day pad ________(Amount) / Night pad _______(Amount)

Are there any problems with the pads? ____

If yes specify ____

How many unopened packs of pads are left at present? ____

Does the pad order need to be amended? ____

Give contact number of continence department in case of pad queries. 028 25 635278

Details of any Aids Provided

From District Nurse	From O.T.
Commode	Raised toilet seat
Urinal	Hand rails
Sheath System	Other
Washable Pants	
Beam bridge funnel	
Catheters? Type Bags	

Result of Assessment

Has a Care Pathway been followed? ____

If so which pathway? ____

Has continence problem improved?____

Has continence problem deteriorated?____

Pads requested: Daytime:__________________________ Night time:__________________________

Amount:__________________________ Amount:__________________________

If any problems are highlighted during this review that you are unable to deal with, refer to District Nursing Sister. Referred to District Nursing Sister: Yes / No Date________________

Signed:__________________________________ Date: __________________________________

Senior Nurse Sign: __________________________ Date: __________________________________

RETURN ADDRESS
Continence Department,
Spruce House, Braid Valley Hospital, Ballymena BT43 6HL
Tel: 028 2563 5283