

CHSP Home Support Assessors/HACC PYP Living at Home Assessors :BLADDER AND BOWEL SCREENING TOOL

Client Name:

Client ID or Address:

Date of Assessment:

Name of Assessor:

BLADDER HEALTH		What would they like to do about this?
Do you have any problems controlling your urine?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you sometimes find your underwear gets wet when you cough, sneeze or laugh?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you have trouble holding on to urine before reaching the toilet?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you need to go to the toilet more than 6 times a day to pass urine?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you need to get up more than once through the night to pass urine?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Does your urine ever leak out unexpectedly?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you have difficulty passing urine?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you feel any pain or burning when you pass urine?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you ever wear continence aids (pads) to protect your clothing?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
How long has this been a problem for you?		Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Are you currently receiving any assistance with this—or have done in the past	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>

BOWEL HEALTH	Was it identified	What would they like to do about this?
Do you have problems keeping control of your bowels?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
How often would you generally use your bowels? More or less than three times a week?	More than 3? <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you get constipated?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
What does your stool usually look like? (Bristol Stool Chart)		Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you feel any pain or see any blood when you pass stools?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Do you ever use pads or tissues to protect your clothing?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
How long has this been a problem?		Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>
Are you currently receiving any assistance with this—or have done in the past?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Nothing <input type="checkbox"/> Request Advice <input type="checkbox"/> Request Assistance <input type="checkbox"/>

Was a continence issue identified? By Client: YES ☐ NO ☐ By Staff Member: YES ☐ NO ☐

Was client VERBAL / WRITTEN (circle) consent received to refer to continence support?:

Recommendation / Referral (s):

Refer to District Nursing YES ☐ NO ☐

Refer to Continence Nurse Advisor/Consultant YES ☐ NO ☐

Refer to General Practitioner YES ☐ NO ☐

Other: _____ YES ☐ No ☐

Refer to Community Support Staff if appropriate: Yes ☐ No ☐