Agency Logo

GRAMPIANS REGION CONTINENCE PROGRAM

COMMUNITY NURSING BLADDER AND BOWEL SCREENING TOOL

Client Name: Client ID or Address:

Date of Assessment: Name of District Nurse:

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

*Commonwealth Home Support Programme/Home and Community Care Program for Younger People, Grampians Region

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

Was a continence issue identified? YES ☐ NO ☐

What issues were identified that need intervention? _____

_____

_____

Recommendation (s):

Complete a District Nursing Continence Assessment: YES ☐ NO ☐ Date for District Nursing Continence Assessment: _____

Then undertake a:

District Nurse managed continence plan: YES ☐ NO ☐

OR Refer to a Continence Nurse Advisor/Consultant: YES ☐ NO ☐

OR Refer to the General Practitioner YES ☐ NO ☐