**Name: NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Done By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Continence Review Questionnaire - For use by Specialist Nurses, Registered Nurses or Band 3 HCAs and above.**

1. Initial Diagnosis of Bladder / Bowel Dysfunction

Comments: Urgency and frequency and urge urinary incontinence.

2. Current Treatment and Management

Comments: Altered fluids / avoiding constipation / commode in use by bed at night / continence products

3. Please assess the patient’s skin condition / pressure areas. Are there any

 concerns? What action has been taken (Pressure Ulcer Risk Assessment Tool)?

 Are barrier creams in use?

Comments: No concerns about skin condition.

**2. History Review**

1. Changes to Medical History / Medication (relevant to bladder/bowel function).

Comments: The only change is that A has been unwell recently and mobility has deteriorated which is making it more difficult for her to get to the toilet on time.

 2. Urinalysis Result and rationale for sending MSU if sent.

Comments: MSU taken to surgery to be checked.

x

 3. MSU Sent? Yes No

Comments: Will be sent on if surgery suspect UTI when tested.

x

 4. Bladder Scan Required? Yes No

Comments:

x

5. Symptom Profile Attached? Yes No

Comments:

x

6. Frequency Volume chart completed and attached? Yes No

Comments: See attached. There is an increase in urinary incontinence since last chart completed.

x

7. Bowel chart completed and attached? Yes No

Comments:

8. Treatment Plan (and results from bladder scan/charts if done).

Comments: Await urine results. And request continence products in a higher absorbency to be changed from next Nursing Home delivery please.

x

9. Does the patient require continence containment products? Yes No

Comments:

x

10. Is there a change to containment products? Yes No

Comments:

If so complete Product Requirement Form.

11. Next review date or discharged

Comments: Review if current allocation no longer suitable

**Ward Staff Only -** Please post to Clare Markwell, Bladder and Bowel Health Service, Clifton Health Centre **(Internal Mail)**

**Nursing Homes –** Pleasecomplete on paper and send (with a product requirement form and bladder / bowel charts) to:-

Bladder and Bowel Health Service

Clifton Health Centre

Water Lane

YORK

YO30 6PS