Bladder and Bowel

If someone is completing the form with you or on your behalf

Resident name:_____

Care home: _____Unit/Room number: _____

Resident DOB/CHI:_____

Name of person completing form:_____

Relationship to resident: _____

Describe in your own words your bladder and/or bowel problem including the length of time it has been troubling you.

_____

_____

_____

_____

_____

_____

Please list your medication.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had your bladder or bowel assessed before?

☐ Yes ☐ No ☐ Unsure

If **Yes**, when? _____

And by whom ☐ GP ☐ Nurse ☐ Hospital

☐ Other (please state) _____

What was the outcome? _____

_____

Do you leak urine? ☐ Yes ☐ No

If yes, how often do you leak urine?

☐ Never ☐ Occasionally ☐ Weekly ☐ More than once per week

☐ Daily ☐ More than once per day

How wet are you if you do not wear a pad?

☐ Light ☐ Moderate ☐ Heavy

When does leakage of urine occur?

☐ Day only ☐ Night only ☐ Both day and night

Overall, how do your bladder problems affect your everyday life on a scale of 1 to 10, 10 being most?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Not at all A great deal

Do you wear a pad? ☐ Yes ☐ No

If yes, who provides them? ☐ NHS ☐ Self purchased

Name of the pad you use _____

How many do you use? Day _____ Night ____

Do you have any pain when passing urine?	☐ Yes	☐ No
Do you have or have you ever seen blood in your urine?	☐ Yes	☐ No
Do you have a lot of urine infections? (more than 3 per year)	☐ Yes	☐ No

Please answer all the following questions about your bladder problems

STRESS INCONTINENCE		
Do you leak urine when you laugh, cough, sneeze or lift?	☐ Yes	☐ No
Do you leak without feeling the need to empty your bladder?	☐ Yes	☐ No
Are you aware of leakage occurring?	☐ Yes	☐ No

Mainly **Yes** answers indicate you may have stress incontinence.

INCOMPLETE EMPTYING/OVERFLOW INCONTINENCE		
Do you find it difficult to start to pass urine?	☐ Yes	☐ No
Do you have to push or strain to pass urine?	☐ Yes	☐ No
Does your flow stop/start several times?	☐ Yes	☐ No
Do you feel as though your bladder is not completely empty after passing urine?	☐ Yes	☐ No
Do you leak into your underwear just after passing urine?	☐ Yes	☐ No
Does your bladder ever completely empty without warning?	☐ Yes	☐ No

Mainly **Yes** answers indicate you may have incomplete bladder emptying/overflow incontinence.

URGE INCONTINENCE/OVERACTIVE BLADDER		
Do you feel a strong sudden urge and have to go to the toilet immediately?	☐ Yes	☐ No
Do you feel the urge to pass urine frequently?	☐ Yes	☐ No
Are you woken up more than twice during the night to pass urine?	☐ Yes	☐ No
Do you sometimes pass urine in your sleep?	☐ Yes	☐ No

Mainly **Yes** answers indicates you may have urge incontinence/overactive bladder.

FUNCTIONAL INCONTINENCE

Do you know when to go to the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty mobilising to the toilet?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty getting onto the toilet and sitting down?	☐ Yes	☐ No	☐ Sometimes
Do you have difficulty in undressing and redressing yourself?	☐ Yes	☐ No	☐ Sometimes
Do you find it difficult to find a toilet?	☐ Yes	☐ No	☐ Sometimes

Mainly **Yes** answers indicates you may have functional incontinence.

BOWELS **Date:** _____

What is your usual bowel pattern (for example daily)? _____

What was the date of your last bowel movement? _____

Do you have bowel incontinence and if so how often?_____

Do you have any of the following symptoms in relation to your bowels?

☐ Straining to pass a bowel motion

☐ Blood on your bowel motion

☐ Feeling of incomplete emptying

Do you take any laxatives? ☐ No ☐ Yes Type:_____

If **Yes**, are they ☐ Regular or ☐ As required

BLADDER SCAN - [This will be completed by the Bladder and Bowel Service].

Date:_____

Pre void:_____

Post Void:_____