HHC Urinary Continence Assessment: Preview

Client: [TST0000]

Current Management

Information obtained from

Problem

Referee Name

Presenting Problem

Current Management

Product ◯ Yes ◯ No

Type

Size

Frequency of change

Day

Night

Managing this condition

☐ Urology
☐ Physio
☐ DN
☐ NS
☐ Urogynae
☐ Aged Care
☐ Gynae
☐ Other

What does the client/caregiver require from this service

Medication Detail

Diet

Fluid intake

Cups per day of

Water

Tea

Coffee

Alcohol

Other

Bowel

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Bowel Regularity/Frequency

Constipation ◯ Yes ◯ No

Faecal Incontinence ◯ Yes ◯ No

Urine

Urine abnormalities		Dysuria	
Haematuria		Unpleasant Odour	
Cloudy		MSU/CSU/Dipstick	

Voiding Pattern

Voids Day		Voids Night	

Describe voiding pattern prior to onset of incontinence

Was anything associated to onset of leakage

Signs and symptoms

Urine leakage occurs if patient:

- ☐ Coughs/laughs
- ☐ Walks/runs
- ☐ Pulls/pushes/lifts
- ☐ Sit to stand
- ☐ With urge sensation

Able to stop in middle of flow

Patient passes frequent & small volumes of urine

Urge triggers (eg key in door, tap running)

Hold On

Can patient "hold on"		Average time	
Leakage occurs if hold on		Volume	

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Stream/Flow

Nocturnal

Woke with full bladder

Incomplete Emptying

Awake and Emptied Bladder

Frequency

Abdomen Examination

Abdominal/Bladder examination ○ Yes ○ No

☐ Palpable ☐ Perusable

Skin Integrity

Contributing Factors

☐ Mobility ☐ Dexterity ☐ Sensory

☐ Communication ☐ Environment

Additional Information

Initiate Toileting

Unwilling to Toilet

Can Locate Toilet

Aware of Wetness

Is Restless Before Toileting

Able to Follow Simple Instructions

Self Toilet

Urine Drainage / Collection

Urinary Catheter

Length

Type

Size

Balloon Size

Long Term

Short Term

Catheter Valve

Link Closed System

Open System

Day Bag

Night Bag

Continence Aids

Continence Aids

Type

Size

Usage

Amount

Current Aids Satisfactory

Comment

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Independent with use of aids

Comment

Differential Diagnosis

Stress Incontinence

Overactive Bladder

Mixed Incontinence

Destusor Failure Partial

Destusor Failure Total

Functional

Assessment & Plan

Bladder Diary

Dipstick / MSU/CSU

Bladder Diary Results

Fluid Intake

Largest Volume

Smallest Volume

Day

Night

Bladder Scan Results

☐ Not able to void on request

Double Void

Pre Void Volume

Post Void Volume

Time of void pre-scan minutes/hrs

Comments

Treatment Plan

Need to Double Void

Bladder Retraining

Pelvic Floor Strengthening

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Medication

Bound Management Program

Refer on to			
Trial of Continence Aids		Type issued	
Date issued		Number issued	
Product prescribed		Type issued	
Date issued		Number issued	
Home Delivery Commenced		Letter to WINZ	
Referral Date			

Patient Goals/Intervention