Waitemata District Health Board
Te Wai Awhina

First Name: _____ **Gender:** _____
Surname: _____
AFFIX PATIENT LABEL HERE
Date of Birth: _____ **NHI#:** _____
Ward/Clinic: **Consultant:**

Ostomy & Continence

Continence Assessment

Referred by	Name of Carer
Family involvement e.g. lives alone	
Current medication frequency & dose	

Relevant past health history

Male	Yes	No	Female	Yes	No
Cystoscopy	❑	❑	Hysterectomy	❑	❑
Urological/Renal surgery	❑	❑	Prolapse	❑	❑
TURP/Radical prostatectomy			Pelvic floor repair	❑	❑
A/P resection	❑	❑	Cystoscopy	❑	❑
Past radiotherapy			Urological/renal surgery	❑	❑
			Past radiotherapy	❑	❑

Other Medical/Surgical history
Gynaecology/ obstetric history

Continence history

Main urinary complaint as a patient/ carer describes
When did the problem start
Any special circumstances (trauma, stress, illness)
Is problem ❑ improving ❑ stable ❑ worsening
Any previous treatment for incontinence

Continence Assessment

Waitemata District Health Board
Te Wai Awhina

First Name: _____ **Gender:** _____
Surname: _____
AFFIX PATIENT LABEL HERE
Date of Birth: _____ **NHI#:** _____
Ward/Clinic: **Consultant:**

Ostomy & Continence

Continence Assessment

Current pattern of micturition Number of day time voids = Number of night time voids = Ability to postpone voiding ❑ Yes ❑ No	.
Urge Incontinence Constant ❑ Yes ❑ No Frequency	***Symptom of not being able to get to or onto the toilet in time***. *Warning time between the first sensation and an urgent need to empty the bladder is curtailed ie a 10 minute warning instead of 1 hour, or so urgent that normal activities have to be interrupted and a toilet found immediately*
Stress incontinence Loss of urine when laughing, sneezing, coughing, physical exertion ❑ Yes ❑ No Ability to interrupt flow ❑ Yes ❑ No	*Symptoms of leaking urine with physical exertion*: ***Mild****: occurs only on strenuous exercise* ***Severe:*** *on rising from a chair or walking*

Degree of overall incontinence

❑ Large ❑ Moderate ❑ Small ❑ None ☐Unknown

Voiding difficulties

Hesitancy	❑ Yes ❑ No	Poor stream	❑ Yes ❑ No
Straining	❑ Yes ❑ No	Manual expression	❑ Yes ❑ No
Post micturition dribble	❑ Yes ❑ No	Sensation of incomplete bladder emptying	❑ Yes ❑ No

Bladder scan result Pre void
Post void

Recent urinary symptoms/ investigations Microscopic urinalysis ❑ Yes ❑ No Dysuria ❑ Yes ❑ No Recent UTI ❑ Yes ❑ No Haematuria ❑ Yes ❑ No	*UTI is not always symptomatic in the older adult*
Bowel habits Are bowels regular ❑ Yes ❑ No Are laxatives or diet regulators used ❑ Yes ❑ No Any faecal incontinence ❑ Yes ❑ No	*Careful enquiry to elicit 'normal' for patient.* *Severe constipation with impaction considerably disturbs bladder function.* *If problems identified complete bowel/faecal incontinence assessment tool*

List laxatives and diet regulators

Continence Assessment

Waitemata District Health Board
Te Wai Awhina

Ostomy & Continence

First Name: _____ **Gender:** _____
Surname: _____
AFFIX PATIENT LABEL HERE
Date of Birth: _____ **NHI#:** _____
Ward/Clinic: **Consultant:**

Continence Assessment

Estimated fluid intake

Type and amount of fluid taken daily

Any fluid restriction

Products currently used to manage incontinence

❑ pads/mobiles ❑ all in one briefs Number per day per night

What brand/absorbency

Are they effective ❑ Yes ❑ No

Source of supply

Is the present regime of managing the problem satisfactory ❑ Yes ❑ No

Is absorbent sheeting used ❑ Yes ❑ No

Intermittent catheterisation ❑ Yes ❑ No

Are external catheters used ❑ Yes ❑ No

Environment and activities of daily living

Ability to perform toilet hygiene independently

Toileting transfer problems

Commode/ urinal used ❑ Yes ❑ No

Laundry facilities ❑ Yes ❑ No

Toilet access ❑ Yes ❑ No

Usual activities; are these restricted ❑ Yes ❑ No

Any sexual problems related to continence ❑ Yes ❑ No

Other comments

Psycho-social impact / goals

Impact of incontinence in patient's own words

Motivated to improve continence

Patient's stated goals

Continence Assessment

Waitemata District Health Board
Te Wai Awhina

First Name: _____ **Gender:** _____
Surname: _____
AFFIX PATIENT LABEL HERE
Date of Birth:_____ **NHI#:** _____
Ward/Clinic: **Consultant:**

Ostomy & Continence

Continence Assessment

Summary of problems	
– *List common causes which need excluding eg infection, constipation* – *Summarise urinary problems as either urge, stress, obstruction, retention or mixed* – *List functional problems e.g. mobility difficulties, loss of eyesight, cognitive problems*	
1	
2	
3	
4	
5	
6	
Action plan / review date	
Assessed by	
Name	**Date**
Signature	**Designation**

Continence Assessment