Reassessment of Bladder and Bowel Function (Level 1)

Reassessment should be carried out when client's needs change, or following treatment interventions, or at least annually.

Name: _____D.O.B. _____ I.D. no_____

Address: _____ Eircode _____

Client's Phone No. _____ Mobile _____ G.P. _____

Contact Person _____ Phone No. of Contact Person _____

Client consents to data collection Yes □ No □ Continence reassessment Yes □ No □

Previous Level 1 Baseline Continence Assessment Completed Yes □ No □

If 'no', do not complete this form. Please complete Level 1 Baseline Continence Assessment including 3 day bladder & bowel record charts.

Information obtained From: Client □ Carer □ Nurse □ Other _____

Information taken: Over phone □ In Person □ Client in Residential Care? Yes □ No □

Please document type of incontinence : urine □ faecal □ Since last assessment / Reassessment are there any changes to the following: (Please give details)
Bladder function No □ Yes □
Bowel function No □ Yes □ Stoma No □ Yes □
Urinary catheter in situ since last assessment/ reassessment No □Yes □
Changes in medical / surgical history No □ Yes □ Urinalysis No □ Yes □ Referred for Medical / GP Review No □ Yes □
Skin Integrity No □ Yes □
Manual Dexterity / Functional ability No □ Yes □
Current Treatment Plan for promoting continence reassessed (Please give details) Toileting program □ Toileting aids □ Fluid intake □ Diet □ Pelvic floor exercise □ Bladder retraining □ Current Treatment plan still effective No □ Yes □ Give details of changes to treatment plan

Details of continence wear currently supplied by the HSE

	Product Name	HSE CODE	AMOUNT
DAY			
NIGHT			
NET PANTS			

Are these products satisfactory for client's needs? Yes □ No □

If no; please state reason _____

_____

New adjusted order for continence wear (only complete this part if a change is required)

	Product Name	HSE CODE	AMOUNT
DAY			
NIGHT			
Net Pants			

If a change in size of product is required please record abdominal girth measurement _____cms

Do you have any overstock of products? Yes □ No □
Details:_____

Are the address & delivery details the same? Yes □ No □
Details:_____

Completed by: _____ Title: _____

Health Centre / Residential Centre / Residential House / Nursing Home:
_____

Telephone no:/Mobile No: _____ Date _____

Please forward to the relevant Coordinator/ Continence Advisory Service (as per local arrangements)

Repeat level 1 assessment received □ **Date**: _____ **Recommendations:** _____

_____

Adjustments: Approved □ Not Approved □ Details: _____

Signed: _____ Date_____