

**Continence Assessment Form**

**– Child who has not yet been toilet trained**

**Patient Details**

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| Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Child’s name:  Male/female | | Parents’ names: |
| Date of birth: | Age: | Siblings: |
| NHS Number/Hospital ID: | |
| Address: | | Home phone: |
| Parent’s email: |
| Mobile 1: | | Mobile 2: |
| GP name and address: | | School Health Nurse/Health Visitor: |
| GP phone number: | | Other relevant health care professionals: |
| GP fax number: | |
| Nursery/school name and address: | |  |
| Nursery/school phone number: | |  |
| Past medical history: | | |
| Medication taken:  Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Timing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Mobility:**  Ambulant / Walks with aids / Wheelchair user  **If wheelchair user:** *Please delete as appropriate*  Able to transfer independently / with assistance  Requires lifting / hoisting  Additional information: | | |
| Learning ability:  Please give details: | | |
| Toileting:  **Has toilet training been attempted in the past?** *Please delete as appropriate*  Yes / No  Please give details: | | |

*Please circle the following answers as appropriate*

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| **Bowels** |
| **Frequency of bowel actions:**  \_\_\_\_\_\_\_\_\_\_\_\_ times a day/week |
| **Stool Type**  1 2 3 4 5 6 7 |
| **Any soiling?**  Yes / No |
| **What protection does the child wear?**  Pants / pad in pants / nappy / pull-up |
| **Does the child use the potty / toilet / neither?**  **Is there a regular toileting programme in place?** Yes / No |
| **Does the child pass LARGE stools / large quantity of stool all at once?**  Yes / No |
| **Any abdominal pain and/or pain on defaecation?**  Yes / No |
| **Any abdominal distension?**  Yes / No |
| **Any anorexia / nausea / vomiting / faltering growth?**  Yes / No |
| **Any other associated behaviour – straining / stool withholding / toilet avoidance / passing stools at night?**  Yes / No |
| **Has child been seen by GP/Paediatrician for physical examination to rule out underlying organic cause – ‘red flags’?**  Yes / No / Referred |

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| **Daytime Bladders** |
| **Frequency of voids:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ times a day |
| **Voiding behaviour:**  **Any hesitancy?**  Yes / No  **Any straining to initiate void?**  Yes / No  **Is stream weak/interrupted?**  Yes / No |
| **History of Urinary Tract Infection (UTI)**  Yes / No  **Number of UTIs in the last year**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Current UTI suspected?**  Yes / No  **Urinalysis performed?**  Yes / No  Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Specimen sent?**  Yes / No  Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What protection does the child wear?**  Pants / pad in pads / nappy / pull-up |
| **What are the child’s usual drinks/feeds?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How many drinks/feeds does the child have every day?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Are drinks/feeds evenly spread throughout the day?**  Yes / No  **Average daily fluid intake?**  \_\_\_\_\_\_\_\_\_\_mls |
| **Has child been seen by GP/Paediatrician for physical examination to rule out underlying organic cause?**  Yes / No / Referred |

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| **Night Time Bladders** |
| **Is the child occasionally or regularly wet at night?**  Yes / No  If yes – continue assessment below. |
| **Is the wetting:**  **Primary** – the child has never been dry at night for a 6 month period  **Secondary** – the child has been dry at night for at least 6 months prior to this episode |