

**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 / hoistingAdditional information: |
| Learning ability:Please give details: |
| Toileting:**Has toilet training been attempted in the past?** *Please delete as appropriate* Yes / NoPlease 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 / NoResult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Specimen sent?** Yes / NoResult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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 / NoIf 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  |