Continence Assessment Form – Child who has not yet been toilet trained

Patient Details

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

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

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

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