

**Continence Assessment Form - Child that has 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*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 / NoIf yes:**Amount?** Stain in pants or on pad / modest amount / full bowel action **Frequency?**Several times a day / daily / less frequently  |
| **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 |
| **Urinary urgency** Yes / No |
| **Volume of voids:**Maximum voided volume \_\_\_\_\_\_\_\_\_\_\_\_mls(Exclude first void of the day)Expected bladder volume \_\_\_\_\_\_\_\_\_\_\_\_mls |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Any daytime wetting?** Yes / NoIf yes:**Amount?** Damp pants / wet through to outer clothes / puddle **Frequency?**Several times a day / daily / less frequently**When do the problems primarily occur?** Prior to voiding / after voiding / associated with laughing / randomly |
| **What protection does the child wear?** Pants / pad in pads / nappy / pull-up |
| **What are the child’s usual drinks?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How many drinks does the child have every day?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Are drinks 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. If no – does the child get up to void during the night:Never / infrequent (less than 4 times a week) / frequent (4 or more times a week) / once a night / more than once a night. |
| **Is the wetting:****Primary** – the child has never been dry at night for a 6 month period**Secondar**y – the child has been dry at night for at least 6 months prior to this episode  |
| **Does the child wake after wetting?** Yes / No |
| **Does the child wet once a night / more than once a night?**  |
| **Volume of wetting:** Just night wear / wet patch the size of a dinner plate / wet patch covering most of the middle of the bed / most of the bed wet, including pillow and duvet |
| **Time of wetting:** Soon after going to bed / later in the night |
| **Size of morning void:** Unable to void / small / medium / large |
| **Colour of morning void:**Dilute / concentrated |
| **Time of last drink**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What time does the child go to bed?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Does the child void before going to bed?**Yes / No**Does the child void before going to sleep?**Yes / No**What time does the child go to sleep?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Does the child share a bedroom?** Yes / NoSingle bed / Cabin / Bunk – top/bottom |
| **Will the child go to the toilet if they wake?**Yes / No Any concerns? |