Continence Assessment Form - Child that has 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:		

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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

Bowels

Frequency of bowel actions:

_____________ times a day/week

Stool Type
1 2 3 4 5 6 7

Any soiling?
Yes / No

If 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

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Does the child pass LARGE stools / large quantity of stool all at once?
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

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

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Number of UTIs in the last year ________

Current UTI suspected?
Yes / No

Urinalysis performed?
Yes / No
Result ____________________________

Specimen sent?
Yes / No
Result ____________________________

Any daytime wetting?
Yes / No
If 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

Night Time Bladders

Is the child occasionally or regularly wet at night?
Yes / No

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If 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
Secondary – 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 / No

Single bed / Cabin / Bunk – top/bottom

Will the child go to the toilet if they wake?
Yes / No
Any concerns?

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