# Transdisciplinary Patient/Client Continence Assessment Tool

## PERSONAL DATA

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<tr>
<th>Scope of Practice</th>
<th>Continence Advisor</th>
<th>RN</th>
<th>RPN</th>
<th>Initials / Designation</th>
<th>Date yyyy/mm/dd</th>
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<tbody>
<tr>
<td>Date of Birth</td>
<td>YYYY / MM / DD</td>
<td>Age</td>
<td>Gender</td>
<td>❑ Male ❑ Female</td>
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## INCONTINENCE HISTORY

- **Type**
  - ❑ Urinary Incontinence
  - ❑ Fecal Incontinence
  - ❑ Both
  - ❑ Other

- **Onset**
  - ❑ Sudden
  - ❑ Gradual

- **Duration**
  - ❑ < 6 months
  - ❑ 6 months - 1 year
  - ❑ 1-2 years
  - ❑ 2-5 years
  - ❑ > 5 years

- **Incontinence over the past 6 months**
  - ❑ Worsening
  - ❑ Stable
  - ❑ Improving
  - ❑ Fluctuates

- **What do you think has caused the problem?**

- **How often do you go to the toilet during the day?**

- **Do you have any accidents during the waking hours?**
  - ❑ Yes ❑ No
  - If Yes, how often?
    - ❑ < 1 day
    - ❑ 1 per day
    - ❑ 1 per week
    - ❑ 2-6 per week
    - ❑ 1 per month
    - ❑ Not known

- **Does urine or feces**
  - ❑ Soil/wet underwear only
  - ❑ Soil outer clothing
  - ❑ Run down your legs
  - ❑ Pool on the floor
  - ❑ Remain within containment product

- **Is the amount**
  - ❑ Consistent
  - ❑ Variable

- **Does the need to go wake you up?**
  - ❑ Yes ❑ No

- **How often do you go to the toilet after going to bed?**

- **Do you have accidents at night?**
  - ❑ Yes ❑ No
  - If Yes, how often?
    - ❑ 1 per night
    - ❑ >1 per day
    - ❑ 1 per week
    - ❑ 2-6 per week
    - ❑ 1 per month
    - ❑ Not known

- **How much leakage?**
  - ❑ Wets/soils incontinent product
  - ❑ Wets/soils bedding
  - ❑ Wets/soils night attire
  - ❑ Additional soiling

- **Do you leak urine or feces with physical stress (i.e., Cough, laugh, sneeze, lift, jump)?**
  - ❑ Yes ❑ Yes, just after ❑ Occasionally ❑ Not known ❑ No

- **Do you have to rush to the bathroom when you feel the urge?**
  - ❑ Yes ❑ No ❑ Occasionally ❑ Not known

- **On average, how long can you hold on after feeling the first urge?**
  - ❑ Not at all
  - ❑ < 5 minutes
  - ❑ 5-15 minutes
  - ❑ >15 minutes
  - ❑ Varies
  - ❑ Not known
### INCONTINENCE HISTORY

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- Do you feel that you completely empty your bladder when you pass urine?  
  ❑ Yes  ❑ No
- Are you aware of the urge to void or move your bowels?  
  ❑ Yes  ❑ No  ❑ Not known
- Are you aware of passing urine?  
  ❑ Yes  ❑ No  ❑ Not known
- Are you aware when wet/soiled?  
  ❑ Yes  ❑ No  ❑ Not known

### BLADDER

- Do you have:
  1. Hesitancy  ❑ Yes  ❑ No  ❑ Not known
  2. Straining/manual expression  ❑ Yes  ❑ No  ❑ Not known
  3. Poor stream  ❑ Yes  ❑ No  ❑ Not known
  4. Dysuria (difficult or painful urination)  ❑ Yes  ❑ No  ❑ Not known
  5. Post-micturition dribble  ❑ Yes  ❑ No  ❑ Not known
  6. Constant dribble  ❑ Yes  ❑ No  ❑ Not known
  7. Change in odour of urine in past 6 months  ❑ Yes  ❑ No  ❑ Not known
  8. Hematuria (blood in urine)  ❑ Yes  ❑ No  ❑ Not known

- What type of product is used for containment? (specify)
  How many are used every 24 hours?

### FLUID INTAKE

- Do you restrict your fluids?  ❑ Yes  ❑ No  ❑ Sometimes
- How much do you drink in a day, including water?  *(Describe in cups [1 cup = 250 mL]*)
  Breakfast _____ cups  
  Mid-morning _____ cups  
  Lunch _____ cups  
  Mid-day _____ cups  
  Supper _____ cups  
  Evening _____ cups  
  DAILY TOTAL = _____ cups

### RISK BEHAVIOURS

- Do you drink beverages containing caffeine?  ❑ Yes  ❑ No
  _____ cups per day
- Do you drink any alcoholic beverages?  ❑ Yes  ❑ No
  _____ drinks per day

### BOWEL

- What has been your bowel pattern in the last six months?  
  ❑ Daily  ❑ 2-3 times a day  ❑ 3 times per week  ❑ Other:
  ❑ Yes  ❑ No

- Is this a change from your previous normal pattern?  
  If Yes, when did this occur?  
  ❑ Yes  ❑ No

- Do you frequently have hard or difficult bowel movements?  ❑ Yes  ❑ No

- Any detection of blood in your bowel movement?  ❑ Yes  ❑ No

- Any pain with bowel movement?  ❑ Yes  ❑ No
  If Yes, describe:
### BOWEL

**Scope of Practice** | **Continence Advisor** | **RN** | **RPN**
--- | --- | --- | ---

- **Do you have hemorrhoids?**
  - Yes □
  - No □

- **Is diet used to keep your bowels regular?**
  - Yes □
  - No □

- **Indicate product(s) or procedure(s) used for regulation:**
  1. Laxatives
  - Yes □
  - No □
  2. Suppositories
  - Yes □
  - No □
  3. Enemas
  - Yes □
  - No □
  4. Manual disimpaction
  - Yes □
  - No □
  5. Other (specify)
  - Yes □
  - No □

- **Do you have loose bowel movements?**
  - Yes □
  - No □
  
  If Yes, how often?

- **Do any foods contribute to loose stools?**
  - Yes □
  - No □
  
  If Yes, which food(s)?

### MEDICAL HISTORY

**Scope of Practice** | **Continence Advisor** | **RN** | **RPN**
--- | --- | --- | ---

- **Previous Surgery**
  - Trans Urethral Prostatectomy (TURP)
  - Abdominal Hysterectomy
  - Vaginal Hysterectomy
  - Bladder Repair
  - Abdominal Peritoneal Resection

- **Medical Conditions**
  - Stroke (CVA)
  - Parkinson’s Disease
  - Multiple Sclerosis
  - Diabetes Mellitus
  - Fractured Hip
  - Urinary Tract Infection
  - Cancer
  - Glaucoma
  - Renal Stones
  - Dementia
  - Arthritis
  - Other (specify)
<table>
<thead>
<tr>
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</table>

### Abilities Assessment

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Occasionally</th>
<th>Unable to answer</th>
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</thead>
<tbody>
<tr>
<td>Aware of urge to void</td>
<td></td>
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<tr>
<td>Able to find the toilet</td>
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<tr>
<td>Able to understand reminders or prompts</td>
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<tr>
<td>Able to ask for assistance</td>
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<tr>
<td>Able to remove clothing to toilet</td>
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<tr>
<td>Able to sit on the toilet/hold the urinal</td>
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<tr>
<td>Motivated to be continent</td>
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<tr>
<td>Socially aware of appropriate place to pass urine</td>
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### Childbirth

- Have you experienced childbirth? [ ] Yes [ ] No
  - If YES, total # of deliveries ______
- With your vaginal deliveries, did you have
  - 1. Forceps [ ] Yes [ ] No
  - 2. Breech [ ] Yes [ ] No
  - 3. Posterior [ ] Yes [ ] No
  - 4. Tears [ ] Yes [ ] No
  - 5. Episiotomy [ ] Yes [ ] No
  - 6. Prolonged labour [ ] Yes [ ] No
  - 7. Heavy babies [ ] Yes [ ] No
- Caesarean section? [ ] Yes [ ] No
- Menopause? [ ] Yes Age __________

### Medication Review

- Any medication with the following actions:
  - 1. Anticholinergic [ ] Yes [ ] No
  - 2. Cholinergic [ ] Yes [ ] No
  - 3. Diuretics [ ] Yes [ ] No
  - 4. Estrogen [ ] Yes [ ] No
  - 5. Sedative/Hypnotic [ ] Yes [ ] No
  - 6. Antidepressant [ ] Yes [ ] No
  - 7. Antispasmodic [ ] Yes [ ] No
  - 8. Antipsychotic [ ] Yes [ ] No
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<tr>
<th>PHYSICAL ASSESSMENT</th>
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<tbody>
<tr>
<td>Perineal Skin</td>
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<tr>
<td>□ Intact</td>
<td>□ Redness</td>
<td>□ Excoriation</td>
<td>□ Other:</td>
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<tr>
<td>Personal Hygiene</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>uses soap</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Voided Volume</td>
<td></td>
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<tr>
<td>Residual urine</td>
<td>□ Yes</td>
<td>□ No</td>
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<tr>
<td>Volume =</td>
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<tr>
<td>Catheterization</td>
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<tr>
<td>Ultrasound</td>
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<tr>
<td>Sent for culture/sensitivity?</td>
<td>□ Yes</td>
<td>□ No</td>
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**Female**

- Atrophic vaginal changes noted on visual inspection □ Yes □ no
- Vaginal discharge □ Yes □ No
  - If YES, swab sent □ Yes □ No
  - Results:

  - Cystocele □ Grade I – Small □ Grade II – Moderate
  - □ Grade III – Beyond Introitus □ Absent □ Not assessed

- Rectocele □ Yes □ No
- Able to contract pelvic floor □ Yes □ No
- Circumvaginal muscle strength (Oxford Scale)
  - □ Nil □ Flicker □ Weak □ Moderate □ Good □ Strong □ Not assessed

**Male**

- Epispadias □ Yes □ No
- Hypospadias □ Yes □ No
- Retracted penis □ Yes □ No

**Rectal Examination**

- Perianal sensation □ Present □ Reduced □ Absent
- Anal tone □ Present □ Reduced □ Absent

**CONTRIBUTING FACTORS**
<table>
<thead>
<tr>
<th>CATEGORY</th>
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<tbody>
<tr>
<td>Stress</td>
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<tr>
<td>Urge</td>
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<tr>
<td>Stress/urge</td>
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<td>Overflow</td>
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<tr>
<td>Functional</td>
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<tbody>
<tr>
<td>Iatrogenic</td>
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<td>N/A</td>
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<tr>
<td>Other:</td>
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### TREATMENT OPTIONS

1. Prompted voiding
   - Initiated
   - N/A
2. Kegel pelvic floor exercises
   - Initiated
   - N/A
3. Urge suppression
   - Initiated
   - N/A
4. Fluid intake changes
   - Initiated
   - N/A
5. Caffeine reduction
   - Initiated
   - N/A
6. Intermittent catheterization (self/caregiver)
   - Initiated
   - N/A
7. Bedside commode
   - Initiated
   - N/A
8. Caregiver instruction
   - Initiated
   - N/A
9. Personal hygiene
   - Initiated
   - N/A
10. Incontinence product education
    - Initiated
    - N/A
11. Education about aids and appliances
    - Initiated
    - N/A
12. Other:
    - Initiated
    - N/A

### REFERRAL

- Referral to:
### NOTES

**SOAP LEGEND**  
- **S** = Subjective  
- **O** = Objective  
- **A** = Analysis  
- **P** = Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Discipline</th>
<th>SOAP Notes</th>
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Acknowledgement

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