**Name: NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Done By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Continence Review Questionnaire - For use by Specialist Nurses, Registered Nurses or Band 3 HCAs and above.**

1. Initial Diagnosis of Bladder / Bowel Dysfunction

Comments:

2. Current Treatment and Management

Comments:

3. Please assess the patient’s skin condition / pressure areas. Are there any

concerns? What action has been taken (Pressure Ulcer Risk Assessment Tool)?

Are barrier creams in use?

Comments:

**2. History Review**

1. Changes to Medical History / Medication (relevant to bladder/bowel function).

Comments:

2. Urinalysis Result and rationale for sending MSU if sent.

Comments:

3. MSU Sent? Yes No

Comments:

4. Bladder Scan Required? Yes No

Comments:

5. Symptom Profile Attached? Yes No

Comments:

6. Frequency Volume chart completed and attached? Yes No

Comments:

7. Bowel chart completed and attached? Yes No

Comments:

8. Treatment Plan (and results from bladder scan/charts if done).

Comments:

9. Does the patient require continence containment products? Yes No

Comments:

10. Is there a change to containment products? Yes No

Comments:

If so complete Product Requirement Form.

11. Next review date or discharged

Comments:

**Ward Staff Only -** Please post to Clare Markwell, Bladder and Bowel Health Service, Clifton Health Centre **(Internal Mail)**

**Nursing Homes –** Pleasecomplete on paper and send (with a product requirement form and bladder / bowel charts) to:-

Bladder and Bowel Health Service

Clifton Health Centre

Water Lane

YORK

YO30 6PS