# Community Nursing Bladder Assessment

<table>
<thead>
<tr>
<th>Surname:</th>
<th>First Name:</th>
<th>Date:</th>
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<tr>
<th>DOB:</th>
<th>Sex:</th>
<th>Referred by:</th>
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<tr>
<td></td>
<td>□ M</td>
<td>□ F</td>
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## Presenting Problems, Previous Treatment & Management Strategies:

### Onset:
- □ sudden
- □ gradual

### Is Condition:
- □ improving
- □ same
- □ worsening

## How Does Your Bladder Problem Affect Your Life?

## Client’s Treatment Goal:

### Medical History

- □ Diabetes
- □ Dementia
- □ Chronic cough
- □ Nicotine use
- □ Allergy
- □ Mental health condition
- □ Neurological Disease

### Surgical History

- □ Recurrent UTI
- □ Obstity
- □ Back pain
- □ Spinal Injury: if yes refer to neurogenic bladder assessment
- □ Other

- □ Cystoscopy
- □ Urethral dilatation
- □ TURP
- □ Radical
- □ Prostatectomy
- □ Artificial
- □ Other

### Medication

- □ Diuretic
- □ Anticholinergic
- □ Antidepressant
- □ HRT
- □ Hypnotic
- □ Laxative
- □ Other

### Function

- □ toilets independently
- □ assisted toileting
- □ prompted toileting
- □ inappropriate toileting
- □ unwilling to use toilet
- □ restless prior to leakage
- □ requires assistance to wipe self after toileting

### Comment:

### Urine:

- □ Burning/scalding
- □ Haematuria
- □ UTI

### Past UTI’s:

### Mobility

- □ mobile
- □ impaired
- □ walks with aid
- □ wheelchair
- □ bed bound
- □ other

### Childhood Urological History

- □ Nocturnal enuresis
- □ Day time wetting
- □ Other
### Obstetric/Gynae History
- Number of pregnancies: ________________________
- Number of births: ______________________________
- Large baby (>4kg): _________________________
- Last PAP smear: ____________________________
- Year of menopause: ________________________
- Last mammogram: _________________________

### Environmental Barriers
- Chair height □
- Toilet height □
- Rails □
- Lighting □
- Mats □
- Clothing □
- Other ______________________

### Cognitive Function
- Dementia: □ mild □ moderate □ severe
- Developmental Disability: □ mild □ moderate □ severe
- Other: ____________________________

### Hand Function
- Good □
- Limited □
- Poor □
- Other ______________________

### Communication
- Normal □
- Impaired □
- Other ______________________

### Bladder Diary
- Chair height □
- Toilet height □
- Rails □
- Lighting □
- Mats □
- Clothing □
- Other ______________________

### Type of Bladder Dysfunction
<table>
<thead>
<tr>
<th>Type of Bladder Dysfunction</th>
<th>Questions to ask client</th>
<th>Amount of leakage</th>
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</thead>
<tbody>
<tr>
<td>Stress Incontinence</td>
<td>Do you leak when you:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ cough, laugh or sneeze?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ go upstairs/down hill?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ get up from chair/bed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ few drops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 50c piece</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ large</td>
</tr>
<tr>
<td>Overactive Bladder &amp; Urge Incontinence</td>
<td>How long can you hold on after you feel a desire to void?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ up to 2 mins □ up to 5 mins □ over 5 mins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you feel an urgent desire to void when you hear running water or put your key in the door? yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the desire so great that you would leak if you did not go toilet immediately? yes □ no □</td>
<td></td>
</tr>
<tr>
<td>Nocturnal Enuresis</td>
<td>Do you wet the bed: yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, how often? ____________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ few drops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 50c piece</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ large</td>
</tr>
<tr>
<td>Overflow Incontinence</td>
<td>▪ Do you know when urine is leaking? yes □ no □</td>
<td></td>
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<tr>
<td></td>
<td>▪ Are you wet the whole time? yes □ no □</td>
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<tr>
<td></td>
<td>▪ Do you feel you completely empty your bladder? yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Is your stream slow to start yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Do you have to strain to pass urine? yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ few drops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 50c piece</td>
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<tr>
<td></td>
<td></td>
<td>□ large</td>
</tr>
<tr>
<td>Reflex Incontinence</td>
<td>Does your bladder empty without warning yes □ no □</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ few drops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 50c piece</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ moderate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ large</td>
</tr>
<tr>
<td>Post Micturition Dribbling</td>
<td>Do you leak immediately after voiding?</td>
<td>yes □ no □</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>□ few drops □ 50c piece □ moderate □ large</td>
<td></td>
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**Male Stream** (see diagram) □ <5 □ 5-10 □ 10-15 □ 15 – 20 □ 20 – 25

Comments: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Bowel Symptoms** (tick all relevant)

If yes to any of the following - please perform bowel assessment

- □ constipation/straining
- □ faecal incontinence
- □ faecal soiling
- □ poor dietary fibre intake <25gm day
- □ other bowel symptoms

Usual stool type: Bristol Stool Form Scale 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □

Comments: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Physical Examination**

**Skin Condition** - perineum, groin, thighs, buttocks:

- □ intact
- □ redness
- □ excoriated
- □ other

Comments: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Urogenital inspection:**

**Females:** □ NAD □ leakage on cough test (for stress incontinence): □ no leakage □ leakage-amount

- □ atrophic vaginitis
- □ vaginal prolapse
- □ urethral caruncle
- □ haemorrhoids
- □ other

Comment: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Males** □ NAD □ retracted penis □ hydrocoele □ hypospadias □ haemorrhoids □ other

Post void residual urine volume: _______ mls Urinalysis: _______________________________________

Comments: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________

Have you checked for transient causes of incontinence? “PRAISED” □ yes □ no □

- P - Pharmaceutical. Psychology - causing depression, grief, anxiety
- R - Restricted mobility, retention
- A - Atrophic urethritis or atrophic vaginitis
- I - Infection - urinary (symptomatic)
- S - Stool impaction
- E - Excessive urine output caused by endocrine/cardiovascular disorder, excessive fluid intake and pedal oedema
- D - Dehydration. Delirium and other confusional states

Ref: Managing and Treating Urinary Incontinence D Newman, A Wein, 2nd Ed 2009 (Pg 89).

Comment: ____________________________________________________________
________________________________________
_____________________________________________________________________
_____________________________________________________________________
Assessment fully completed today
Assessment unable to be completed today – to be completed on ________________________

Management Plan

- Bladder training
- Pelvic Floor exercise program - ref to Nurse continence adviser or continence physiotherapist
- Bowel management
- Advise re “good bladder habits”
- Timed toileting
- Prompted toileting
- Toilet positioning for bladder emptying
- Fluid / dietary changes
- Carer education
- Referral to GP / Specialist
- Referral to Nurse Continence Adviser
- Other
- Other
- Other

<table>
<thead>
<tr>
<th>Continence aids required</th>
<th>Yes ☐ No ☐</th>
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<tbody>
<tr>
<td>Trial of pad(s) or appliance</td>
<td>Yes ☐ No ☐</td>
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<table>
<thead>
<tr>
<th>Product name:</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Result of trial:</th>
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<tbody>
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<td>2</td>
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<tr>
<td>3</td>
<td>4</td>
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Apply for:
- PADP
- CAAS
- DVA
Or
Self funded

Comments:

Nurses Name:       Nurses Designation:       Date: