BLADDER EVALUATION

❍ Admission ❍ Readmission ❍ Quarterly ❍ Annual ❍ Significant Change ❍ Other:_____

CURRENT RESIDENT STATUS

Contributing Factors/Conditions: ❑ Cancer ❑ CVA ❑ Multiple Sclerosis ❑ Diabetes Mellitus ❑ Spinal cord injury ❑ Cerebral Palsy ❑ Congestive Heart Failure ❑ Depression ❑ Dementia ❑ UTI ❑ Obesity ❑ Fecal impaction ❑ Constipation ❑ Bladder disorder ❑ Prostate disorder ❑ Kidney disease ❑ Renal dialysis ❑ Stress incontinence ❑ Urge incontinence ❑ Mixed incontinence ❑ Overflow incontinence ❑ Functional incontinence ❑ Transient incontinence ❑ Terminal Dx ❑ Other:_____

Recent Surgery? ❍ No ❍ Yes If Yes, date:_____ Type:_____

Medication Regimen: ❑ Diuretics ❑ Sedative/Hypnotics ❑ Narcotics ❑ Antipsychotics ❑ Antidepressants ❑ Calcium channel blockers ❑ Antispasmodics ❑ Anticholenergics ❑ Alpha-adrenergic agonists ❑ Alpha-adrenergic antagonists ❑ Other:_____

Is Pain Present? ❍ No ❍ Yes If Yes, refer to pain flow sheet

Mental Status

- ❍ Alert/oriented
- ❍ Comatose
- ❑ Confused, follows directions
- ❑ Confused, cannot follow directions
- ❑ Aphasic
- ❑ Depressed/sad
- ❑ Memory loss
- ❑ Resists care
- ❑ Indicators of delirium
- ❑ Other:_____

Functional Status	Indep	Supervision/ Setup	Assist	Dep
Bed Mobility	❍	❍	❍	❍
Transfer/Standing	❍	❍	❍	❍
Walking	❍	❍	❍	❍
Toileting	❍	❍	❍	❍
Personal Hygiene	❍	❍	❍	❍

Contractures: ❍ No ❍ Yes ❑ UE ❑ LE
Pain with movement: ❍ No ❍ Yes
Decreased manual dexterity: ❍ No ❍ Yes
Need for task segmentation: ❍ No ❍ Yes

Vision Status	R	L	Both
Adequate	❍	❍	❍
Adequate w/aid	❍	❍	❍
Poor	❍	❍	❍
Blind	❍	❍	❍

Hearing Status	R	L	Both
Adequate	❍	❍	❍
Adequate w/aid	❍	❍	❍
Poor	❍	❍	❍
Deaf/No hearing	❍	❍	❍

BLADDER STATUS

Onset Date of Incontinence:_____ **Duration of Incontinence:** _____ Days _____ Months _____ Years

Catheter: ❍ No ❍ Yes If yes, specify type and size:_____

Date inserted:_____ Reason for catheter:_____

Plan for removal: ❍ No ❍ Yes, specify:_____

Perception of Need to Void: ❍ Present ❍ Diminished ❍ Absent

Voiding Pattern: Frequency:_____ Amt./voiding _____ mL

Pattern: ❑ Upon rising ❑ After meals ❑ Night time only ❍ No apparent pattern ❑ Other (specify):_____

Bladder Continence Scale:

❍ Complete control ❍ 1 incontinent episode per week ❍ 2-6 incontinent episodes per week ❍ Continent - catheter in place ❍ Daily incontinent episodes (some control) ❍ Daily incontinent episodes (little or no control)

Associated Symptoms: (select all that apply)

❑ Voids often in small amounts	❑ Difficulty stopping stream	❑ Urgency	❑ Hesitancy
❑ Fills bladder/voids large amounts	❑ Dribbles constantly	❑ Burning/Pain	❑ Other (specify)
❑ Unable to void	❑ Dribbles after voiding	❑ Localized edema	_____
❑ Difficulty starting stream	❑ Dribbles while coughing	❑ Dysuria	_____

Relief After Voiding: ❍ Complete ❍ Continued desire to void Comments:_____

Bladder Distended: ❍ No ❍ Yes Emptied by external stimuli: ❍ No ❍ Yes

If yes, by: ❑ Kegel exercises ❑ Warm water over perineum ❑ Other (specify):_____

Residual Urine: ❍ No ❍ Yes If yes, amount: _____ mL **Bladder Scan:** ❍ No ❍ Yes If yes, amount: _____ mL

Pattern of Fluid Intake: Average fluid intake: _____ mL/AM _____ mL/PM _____ mL/NIGHT = _____ mL/24 hrs

Average fluid output: _____ mL/AM _____ mL/PM _____ mL/NIGHT = _____ mL/24 hrs

❑ Refer to Intake/Output Records Fluids preferred:_____

Use of urinary tract stimulants (i.e. caffeine, etc.):_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

BLADDER EVALUATION (Cont'd.)

EVALUATION FOR BLADDER PROGRAM POTENTIAL

Skin Status: (Perineal/Buttocks) ❑ Intact ❑ Some redness ❑ Rashes ❑ Stage 1-4 pressure ulcer/injury (see skin flow sheet)
❑ Skin desensitized to pain or pressure ❑ Other:_____

Environmental Factors/Assistive Devices That Restrict or Facilitate Resident's Toileting Ability: (select all that apply)
❑ Grab bars ❑ Raised toilet seat ❑ Inadequate lighting ❑ Urinal ❑ Bedpan ❑ Commode ❑ Low toilet seat
❑ High toilet seat ❑ Distance to toilet/commode ❑ Bed rails ❑ Restrictive clothing ❑ Clear route to toilet ❑ Restraints
❑ Other:_____

Types of Programs:
❑ Behavioral program
❑ Bladder rehabilitation/training program
❑ Habit training/scheduled toileting program
❑ Pelvic floor muscle rehabilitation program
❑ Prompted voiding program
❑ Other:_____

❍ **Able to participate in program** Evaluation period:_____ to _____
Plan:_____
_____
❑ Program on Care Plan

❍ **Unable to participate in program**
Reason:_____
_____
Re-evaluation date:_____
❑ Interventions to manage incontinence and promote skin integrity on Care Plan

❍ **Resident chooses not to participate in program** (education has been provided to the resident/family on the benefits of participation in a bladder program and the risks of not participating in the bladder program)

Evaluation completed by:_____ _____
Signature/Title *Date*

DATE	TIME	NOTES - ALL ENTRIES MUST BE SIGNED WITH NAME AND TITLE

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed