# BOWEL EVALUATION

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

## CURRENT RESIDENT STATUS

**Contributing Factors/Conditions** (select all that apply): ❑ Constipation ❑ Fecal impaction ❑ Parkinson's Disease ❑ Alzheimer's/Dementia ❑ Spinal injury ❑ Irritable Bowel Syndrome ❑ Cancer/tumor ❑ Chronic pain ❑ CVA ❑ Multiple Sclerosis ❑ C. Difficile ❑ Crohn's Disease ❑ Spina Bifida ❑ Obesity ❑ Terminal Dx ❑ Other:_____

**Diagnoses:**_____

**Recent Surgery?** ❍ No ❍ Yes Date:_____ Type:_____

**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 | Super-vision/ 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 | ❍ | ❍ | ❍ |

## BOWEL EVALUATION

**Onset Date** (if known):_____ **Duration of Incontinence:** _____ Days _____ Months _____ Years
**Reason for Incontinence** (if known):_____

**Usual Elimination Pattern:** Frequency:_____ Time of Day:_____ Amount:_____ Method:_____

**Consistency:** ❑ Soft/formed ❑ Small/dry ❑ Pasty ❑ Hard ❑ Diarrhea ❑ Other (specify):_____

**Briefs:** ❑ Worn during sleep ❑ Worn while awake ❑ Not used

**History of Constipation:** ❍ No ❍ Yes Frequency:_____

**Flatulence:** ❍ Rare ❍ Occasional ❍ Frequent Comments:_____

**Enema Use:** ❍ No ❍ Yes Type:_____ Frequency:_____

**Laxative Use:** ❍ No ❍ Yes Type:_____ Frequency:_____

**Medication Regimen** (select all that apply): ❑ Sedatives/Hypnotics ❑ Narcotics ❑ NSAIDs ❑ Antihistamines ❑ Antacids ❑ Iron Supplements ❑ Laxatives ❑ Diuretics ❑ Psychotropics ❑ Anticonvulsants ❑ Antidepressants ❑ Antidiarrheals ❑ Chemotherapy ❑ Other:_____

**Skin/Perianal Problems:** ❑ Hemorrhoids ❑ Fissures/Fistulas ❑ Bleeding ❑ Irritations ❑ Pain ❑ Other skin problems (specify):_____

**Perception of Need to Defecate:** ❍ Present ❍ Diminished ❍ Absent

**Well Hydrated:** ❍ No ❍ Yes **Average Fluid Intake (24 Hrs)** _____ mL **Average Fluid Output (24 Hrs)** _____ mL
**Fluid Restriction:** ❍ No ❍ Yes _____ Fluids preferred:_____
❑ Drinks caffeinated beverages ❑ Drinks alcoholic beverages regularly ❑ Other:_____

**Foods That:** Stimulate elimination:_____
Inhibit elimination:_____

**Eating Habits:** ❍ Heavy ❍ Medium ❍ Light **Roughage Intake:** ❍ Good ❍ Poor
Current Diet Order:_____ Percent usually eaten:_____%
Comments:_____

**Environmental Factors that Facilitate Resident's Toileting Ability** (select all that apply):
❑ Grab bars ❑ Adequate lighting ❑ Privacy ❑ High toilet seat ❑ Commode ❑ Other:_____

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

# BOWEL EVALUATION PROGRESS NOTES OR RE-EVALUATION NOTES

## BOWEL EVALUATION (Continued)

**Environmental Factors that Restrict Resident's Toileting Ability** (select all that apply):

❑ Low toilet seat ❑ Restrictive clothing ❑ Distance to toilet/commode ❑ Mobility issues ❑ Bed rails ❑ Alarms
❑ Restraints ❑ Behavior issues ❑ Irregular toileting ❑ Other:_____

## EVALUATION FOR BOWEL TRAINING POTENTIAL

❍ **Able/willing to participate in training** Evaluation Period:_____ to _____

**Plan:**_____

_____

❑ Training plan identified on resident's Care Plan

❍ **Unable/unwilling to participate in training**

**Reason:**_____

_____

❑ Interventions to manage incontinence and promote skin integrity identified on resident's Care Plan

Re-evaluation Date:_____

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

| DATE | TIME | NOTES - ALL ENTRIES MUST BE SIGNED WITH NAME AND TITLE |
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| NAME–Last | First | Middle | Attending Physician | Record No. | Room/Bed |
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