

BLADDER ASSESSMENT FORM

Resident Name: _____

Date: _____

1. Admission Information Regarding Urinary Continence Status

Resident is currently continent of bladder <input type="checkbox"/> YES No further assessment necessary at this time. Monitor Resident for <u>RISK FACTORS</u> for Urinary Incontinence <input type="checkbox"/> None <input type="checkbox"/> Impaired mobility <input type="checkbox"/> Dependent transfer (2 person assist) <input type="checkbox"/> Severe cognitive impairment <input type="checkbox"/> Neurological disorders (e.g. multiple sclerosis, diabetes) <input type="checkbox"/> Other: _____	Resident is currently incontinent of bladder <input type="checkbox"/> YES Signs & symptoms of urinary incontinence (Check all that apply and continue to complete rest of Form) <input type="checkbox"/> Urine leakage on way to bathroom <input type="checkbox"/> Clothes or incontinence pad wet <input type="checkbox"/> Urgency – unable to suppress <input type="checkbox"/> Daytime frequency (>8 times during waking hours) <input type="checkbox"/> Nocturia (>2 times at night) <input type="checkbox"/> Nocturnal enuresis (bedwetting) <input type="checkbox"/> Difficulty during urination <input type="checkbox"/> Post void dribbling
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2. Potentially Reversible (Transient) Causes of Urinary Incontinence

Conditions: <input type="checkbox"/> Atrophic Vaginitis <input type="checkbox"/> Delirium <input type="checkbox"/> Dehydration <input type="checkbox"/> Fecal impaction (positive exam) <input type="checkbox"/> Polypharmacy <input type="checkbox"/> Urinary tract infection (within 30 days) <input type="checkbox"/> Urinary retention (history)	Environment: <input type="checkbox"/> Impaired mobility/ambulation <input type="checkbox"/> Decreased manual dexterity <input type="checkbox"/> Decreased vision <input type="checkbox"/> Use of restraints <input type="checkbox"/> Restrictive clothing	Intake: <input type="checkbox"/> Inadequate fluid intake (<30cc/kg body weight/day) <input type="checkbox"/> Excess intake of caffeine and other other bladder irritants (chocolate, carbonated, caffeinated beverages like tea, coffee, citric juices, tomato juice, spicy foods,)
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3. Contributing Diagnosis/Medical Conditions (Check all that apply)

<input type="checkbox"/> Abnormal lab values (↑ calcium, glucose, BUN, creatinine) <input type="checkbox"/> Alzheimer’s Disease/Dementia <input type="checkbox"/> Amyotrophic lateral sclerosis <input type="checkbox"/> Arthritis/degenerative joint disease/severe osteoporosis <input type="checkbox"/> Atrophic Vaginitis <input type="checkbox"/> Calculi/stones <input type="checkbox"/> Bladder <input type="checkbox"/> Kidney <input type="checkbox"/> Cancer Site _____	<input type="checkbox"/> CHF/Edema <input type="checkbox"/> CVA/stroke <input type="checkbox"/> Delirium <input type="checkbox"/> Diabetes <input type="checkbox"/> Falls <input type="checkbox"/> Fecal Impaction/Constipation <input type="checkbox"/> Inadequate urine output <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Pain with movement	<input type="checkbox"/> Parkinson’s Disease <input type="checkbox"/> Polyuria/excessive urine output <input type="checkbox"/> Prolapse (bladder, uterus, rectum) <input type="checkbox"/> Prostatitis/BPH/Prostate Cancer <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Tardive dyskinesia, essential tremors <input type="checkbox"/> Urinary tract infection (history) <input type="checkbox"/> Other: _____
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4. Medication that May be Contributing to Bladder Dysfunction (Check all that apply)

<input type="checkbox"/> Alpha-adrenergic blockers (e.g. Minipres, Cardura, Hytrin) <input type="checkbox"/> Antianxiety (e.g. Valium, Ativan, Xanax) <input type="checkbox"/> Antidepressants/antipsychotics (e.g. Zoloft, Prozac, Elavil, Tofranil)	<input type="checkbox"/> Antihistamine/alpha-adrenergic agonists (e.g. Parkinsonian meds, Ornade) <input type="checkbox"/> Beta-adrenergic agonist (Lopressor, Tenormin, Inderal) <input type="checkbox"/> Calcium channel blocker (e.g. verapamil, nifedipine)	<input type="checkbox"/> Diuretics (e.g. HCTZ, Lasix) <input type="checkbox"/> Narcotic analgesics, opiates (e.g. morphine, dilaudid) <input type="checkbox"/> Sedatives/Hypnotics (e.g. Halcion)
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5. Further Assessment

a. Physical examination performed and recorded	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormalities noted: _____		
b. Urinalysis performed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Results: _____		
c. Post void residual (PVR) - findings of between 150 and 200 mLs bear repeat measurement, PVR ≥ 200 mL is abnormal	_____ mLs (initial measurement)	_____ mLs (repeat measurement)

Residents @ risk for ↑ PVR include those with history of urinary retention seen in residents with neurologic disease such as stroke, spinal cord injury and men with history of prostate disorders

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6. Incontinence Symptom Profile (Check all that apply)

<p>Stress Urinary Incontinence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urine leakage with cough, sneeze, physical activity <input type="checkbox"/> Urine leakage in small amounts (drops, spurts) <input type="checkbox"/> No nocturia or incontinence at night <input type="checkbox"/> Urine leakage without sensation of urine loss 	<p>Urge Urinary Incontinence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Strong, uncontrolled urgency prior to incontinence <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Nocturia > 2 times <input type="checkbox"/> Urine loss on way to toilet room <input type="checkbox"/> Moderate to large amount of urine leakage (gush) <input type="checkbox"/> Enuresis
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Mixed Urinary Incontinence (Symptoms of both stress and urge)

<p>Overflow Urinary Incontinence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty starting urine stream <input type="checkbox"/> Weak or intermittent stream (dribbles) <input type="checkbox"/> Post-void dribbling <input type="checkbox"/> Prolonged voiding <input type="checkbox"/> Feeling of fullness after voiding <input type="checkbox"/> Voiding small amounts often <input type="checkbox"/> PVR > 200 mLs on 2 separate measurements 	<p>Functional Urinary Incontinence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mobility/manual dexterity impairments <input type="checkbox"/> Lack of toilet or toilet substitute <input type="checkbox"/> Use of restraints <input type="checkbox"/> Medication (sedative, hypnotic, CNS depressant, diuretic, anticholinergic, alpha-adrenergic antagonist) <input type="checkbox"/> Pain with movement
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7. Summary and Program Placement Decision:

Based on the above assessment, the resident is most likely experiencing the following type of incontinence:

Stress
 Urge
 Mixed (Urge & Stress)
 Overflow
 Functional

<p>Treatment Program</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder Retaining (able to resist or delay urgency) <input type="checkbox"/> Scheduled toileting/habit training <input type="checkbox"/> Prompted voiding (able to say name & reliably point to 2 objects) <input type="checkbox"/> Not appropriate for toileting or retraining program. <p>Rationale: _____</p>	<p>Additional Interventions That May Benefit Resident:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Change in fluid intake <input type="checkbox"/> Increased dietary fiber <input type="checkbox"/> Change in food or fluid irritants <input type="checkbox"/> Pelvic floor muscle exercises (able to contract muscle) <input type="checkbox"/> Other _____
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8. EVALUATION FOR RESIDENTS WITH INDWELLING CATHETERS (Skip this section if the resident does not have an indwelling urinary catheter)

Residents with indwelling catheters must have at least one of the following conditions (Check all that apply)

- Terminal illness or severe impairment and movement causes intractable pain
- Stage III or IV pressure ulcers in an area affected by incontinence that prevents ulcer healing
- Untreatable urethral blockage causing urinary retention (documented by PVR of > 200mLs) and staff unable to perform intermittent (in and out)catheterization (document reason)
- Need for exact measurement of urine output

IF NONE of the above applies, initiate a voiding trial and document results in the medical record.

Signature _____

Date _____

Reviews

Date	Reason for review	Able to Participate in Bladder Program	Signature
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	