One Gloucestershire   Attends — Dryness you can rely on

Gloucestershire Bladder & Bowel Health Reassessment & Pad Product Order Form

Name:

Date of Birth: DD / MM / YYYY

MRN Number:

NHS Number:

(OR AFFIX HOSPITAL LABEL HERE)

New patient ❑ Reassessment ❑	Own home ❑ Residential ❑ Nursing ❑	
Title: Mr / Mrs / Miss / Ms / Other:		Gender: Male ❑ Female ❑
Surname	Forename	Patient Tel:
Address		GP name:
Postcode		GP practice:

Package of Care Information: Relative ❑ County Council ❑ Private ❑ Delivery instructions explained to Patient/Carer **Yes** ❑ **No** ❑
Number of visits per 24Hrs: First AM time: Last PM time:
Type of incontinence: bladder ❑ bowel ❑ doubly incontinent ❑ catheter in-situ ❑
New patient prescriptions must have: (please tick to confirm enclosed)
Basic assessment ❑ evidence of care plan ❑ 3 day frequency/volume chart ❑ 1 week diet & bowel diary ❑

PRODUCT ASSESSMENT: Please complete by ticking the most relevant box under each category and adding scores at end

Mobility		Day	Night	**Communication**		Day	Night	**Toilet prompting**		Day	Night
Ambulant	0			No Problems	0			No Problems	0		
Walk with assistance	1			Difficulty	1			Needs Prompting	1		
Immobile	2			Non Communicating	2			Fully Dependant	2		
Mental Status				**Manual Dexterity**				**Toileting**			
Fully Alert	0			Good	0			Self-caring	0		
Slightly Confused	1			Restricted	1			Needs Assistance	1		
Disorientated	2			Very limited	2			Fully Dependant	2		
Incontinent				**Frequency of urination**				**Average void of urine**			
Occasionally	1			Less than 4 times	6			Less than 100mls	1		
Usually Urinary/ Toileting Program	3			4 – 7	4			100-200mls	2		
				8 - 10	2			200-300mls	6		
Doubly incontinent	8			More than 11 times	1			300-400mls	8		
Faecal Only – complete bowel assessment								More than 400 mls	10		
								TOTAL SCORE			

Current Products being used and does leakage from the pad occur Yes ❑ No ❑	**Daytime usage (washable / disposable)**	**Night time usage**	**Stretch Pants Guide measure hip and/or waist in cm's or circle** S M L XL XXL
Please check fitting with appropriate stretch pants or close fitting underwear			

REASSESSMENT: Complete product assessment and clinical assessment

Clinical Assessment Notes	**Yes**	**No**	**Comments/Actions from review**
Repeat Frequency Volume Chart	❑	❑	
New Bowel problems	❑	❑	
Change in Diet	❑	❑	
Change in Medication	❑	❑	
Change in Mobility	❑	❑	
Change in Mental state	❑	❑	
Change in Pad Usage (please specify reason)	❑	❑	

Nurse assessing signature	Print name	
Designation	Date	Time