One Gloucestershire

Name:	
Date of Birth:	DD / MM / YYYY
MRN Number:	
NHS Number:	
(OR AFFIX HOSPITAL LABEL HERE)	

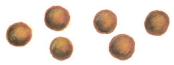
Bowel assessment and referral form

New patient ❑ Reassessment ❑		Own home ❑ Residential ❑ Nursing ❑	
Title: Mr / Mrs / Miss / Ms / Other:			Gender
Surname	Forename		Patient Tel:
Address			GP Practice
Postcode	Assessor name	Contact Tel:	Where assessed

Please describe the presenting bowel problem:

RED FLAGS - If a red flag is identified consult with a medical doctor (check GCare 2 week wait colorectal pathway & GP referral guide) is the patient aware of a colorectal cancer diagnosis within last 5years and has new symptoms.

Rectal bleeding WITH a change in bowel habit looser and/or frequent stools persistent for greater than 6 weeks	Yes ❑ No ❑	Rectal bleeding persistently WITHOUT anal symptoms (sorenes s,discomfort,itching,lumpsand prolapse as well as pain)	Yes ❑ No ❑
A definite palpable anal /rectal mass or ulceration	Yes ❑ No ❑	Trauma to rectum/anus	Yes ❑ No ❑
Iron deficiency anaemia WITHOUT an obvious cause	Yes ❑ No ❑	change in bowel habit to looser and /or increased frequency of stools WITHOUT rectal bleeding and greater than 6 weeks.	Yes ❑ No ❑
A definite palpable right - sided abdominal mass or abdominal pain	Yes ❑ No ❑	Signs of bowel obstruction or faecal impaction	Yes ❑ No ❑
Presenting medical history		**Past medical history**	
Bowel/abdominal surgery	Yes ❑ No ❑	Dementia/cognitive condition	Yes ❑ No ❑
History of bowel dysfunction	Yes ❑ No ❑	Learning disability	Yes ❑ No ❑
Haemorrhoids, anal fissure, rectocele	Yes ❑ No ❑	Mental health	Yes ❑ No ❑
Obstetric injury	Yes ❑ No ❑	Cancer diagnosis - Palliative or end of life care	Yes ❑ No ❑
Spinal cord conditions	Yes ❑ No ❑	Radiotherapy to pelvis/abdomen	Yes ❑ No ❑
Neurological condition	Yes ❑ No ❑		Yes ❑ No ❑
Diabetes	Yes ❑ No ❑	Other	Yes ❑ No ❑
Bowel function (tick all that apply)			
Normal bowel pattern (daily, alternate, longer)	Yes ❑ No ❑	Strains to open bowels	Yes ❑ No ❑
Frequency of bowel motions/day 1,2,3,4, more	Yes ❑ No ❑	Urgency to stool	Yes ❑ No ❑
Bowel frequency once, twice,three times or more/day	Yes ❑ No ❑	Faecal incontinence	Yes ❑ No ❑
Experiences pain with passing a motion	Yes ❑ No ❑	No or little sensation of passing a stool	Yes ❑ No ❑
Feeling of incomplete bowel emptying	Yes ❑ No ❑	Faecal soiling	Yes ❑ No ❑
Difficulty with bowel evacuation	Yes ❑ No ❑	Offensive smelly motions	Yes ❑ No ❑
Current management (tick all that apply)			
Oral laxatives	Yes ❑ No ❑	Enemas/suppositories	Yes ❑ No ❑
Oral bulking agents	Yes ❑ No ❑	Manual evacuation	Yes ❑ No ❑
Rectal washouts	Yes ❑ No ❑	Wears pads	Yes ❑ No ❑
Other influencing factors, lifestyle & wellbeing (tick all that apply)			
Mobility		**Toilet facilities**	
Restricted to bed	Yes ❑ No ❑	Urinary and/or faecal incontinence	Yes ❑ No ❑
Restricted to wheelchair/bed bound	Yes ❑ No ❑	Commode/bedpan	Yes ❑ No ❑
Hoisted	Yes ❑ No ❑	Assistance needed to toilet/commode	Yes ❑ No ❑
Independent	Yes ❑ No ❑	Independent to toilet	Yes ❑ No ❑
Diet and Fluid Intake		**Sacral skin observation**	
Poor diet/NBM	Yes ❑ No ❑	Red and inflamed	Yes ❑ No ❑
NG/PEG feed	Yes ❑ No ❑	Broken skin	Yes ❑ No ❑
Swallowing/chewing problems	Yes ❑ No ❑	Barrier/treatment cream used	Yes ❑ No ❑
Needs assistance to eat	Yes ❑ No ❑	Make referral to TVN CNS	Yes ❑ No ❑
Fluid intake – 8 cups per day	Yes ❑ No ❑	Urinary Catheter in place	Yes ❑ No ❑

The Bristol Stool Chart (BSS) – Circle the stool type				Advice if taking laxatives
TYPE 1		Separate hard lumps, like nuts (hard to pass)	Constipated	Commence or increase softening laxative
TYPE 2		Sausage-shaped but lumpy	Constipated	Commence or increase softening laxative
TYPE 3		Like a sausage but with cracks on its surface	Ideal stool consistency	Maintain laxative dose – consider stimulant laxative
TYPE 4		Like a sausage or snake, smooth and soft	Ideal stool consistency	Maintain laxative dose- consider stimulant laxative
TYPE 5		Soft blobs with clear-cut edges (passed easily)	Slightly too soft	Consider reducing laxative dose
TYPE 6		Fluffy pieces with ragged edges, a mushy stool	loose	Reduce laxative dose
TYPE7		Watery, no solid pieces ENTIRELY LIQUID	loose	Discontinue laxative for a day or two & observe

Care plan - tick when actioned	
Complete bowel assessment	❑
Circle the type of Stool experienced above	❑
Commence a diet and bowel diary GHNSFT/Y0096/04.07 (7 - 14 day if possible)	❑
Perform a visual examination and a digital rectal examination (if competent). If any abnormality is identified document and report any abnormalities to a medical doctor	❑
If BSS type 1- 2 identified consider prescription of laxatives	❑
Advise on toilet position refer to "Improving bowel function and control" (leaflet GHPI1412)	❑
Establish a regular toilet routine – after a hot drink or meal, ideally after breakfast	❑
Review diet and fibre intake. Consider Eatwell Guide or as above leaflet GHPI1412	❑
Review all medication and review those that could cause constipation or diarrhoea	❑
Consider referral to physiotherapy or occupational therapy	❑
Advise on fluid intake – "fluids and caffeine intake for bladder and bowel health" (leaflet GHPI0533)	❑
"Improving bowel function and control" leaflet (GHPI1412) has been given to patient/carer	❑
Refer to the Bladder & Bowel Health team , if all basic interventions have failed , further management needs to be consider or for consideration of a containment product. Please remember to include measurement/size of patient	

Current Products being used and state if they are effective Yes ❑ No ❑	**Day time usage**	**Night time usage**	**Measure hip and/or waist in centimetres or circle** **S M L XL XXL**

Is there a package of care in place **Yes ❑ No ❑** - please inform If Yes name of carers_____	**How many visits per 24 hours**

Nurse assessing signature	Print name	
Designation	Date DD / MM / YYYY	Time 00 : 00