

SPHERE Bladder and Bowel Service
Statement of Case - COMMUNITY

New Client/ Ontex ID No (if known)		Address:	
		Post Code	
DOB/CHI		CHP/BASE:	
GP		Surgery Address:	
Requesting Assessor:		Sent in by:	
		Contact No:	
Background information	Please also detail samples you have already provided and tried by patient.		
Rationale for request	As the assessing nurse, please provide the reason(s) why you consider a non core product necessary for this individual continence needs.		
Further Action anticipated	Please include your follow up and review plans		
Other relevant information	Review checklist on next page – please detail current medication used for bladder and/or bowels.		
Signed:			

FOR OFFICE USE ONLY

DATE REVIEWED:

Is assessor a registered prescriber for products: Yes No

APPROVED:

REJECTED:

Other:

Signed:

Date:

CHECKLIST

Complete for <u>all</u> patients:			YES	NO
Exclude UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exclude constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review medications in relation to bladder and bowel symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess skin conditions and treat accordingly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Modify type and quantity of fluid intake (ref to Fluid matrix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give advice on weight loss if BMI>30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLADDER SYMPTOMS				
Bladder diary completed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no please state why Use bladder diary to plan toileting regime Consider prompted and timed toileting programmes	
Urinalysis:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Results:	
Does the patient have symptoms of a UTI	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, is the patient asymptomatic (encourage fluids) or symptomatic (consider MSSU)	
MSSU necessary	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sent: Results:	
BOWEL SYMPTOMS				
Bowel diary completed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no please state why	
Frequency of bowel action:	Per day/week		Bristol Stool Score: _____	
Urgency of defecation:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Loose stools	Yes <input type="checkbox"/>	No <input type="checkbox"/>	check dietary intake, encourage low fibre diet Consider Loperamide once other causes excluded	
Offensive smelling stool	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Take stool specimen	
Incontinent of faeces:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If rectum empty/loose stool check dietary intake, encourage low fibre diet, consider Loperamide	
Constipated: If rectum is full/partially full – follow Constipation guidelines and give patient Constipation leaflet	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Encourage bowel emptying (apprx 30mins) after meals to utilise gastro colic response Check dietary (high fibre diet) / fluid intake (1.5 litres per day) Encourage gentle exercise (immobility makes constipation worse) Consider appropriate medication to relieve constipation	
Is faecal impaction suspected	Yes <input type="checkbox"/>	No <input type="checkbox"/>	perform DRE in accordance with RCN Guidelines	
Blood in stool:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, refer to GP for further investigations	
Mucus in stool:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, refer to GP for further investigations	
Changes in bowel pattern:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, refer to GP for further investigations	
Consent for rectal examination	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes to blood, mucus or changes in bowel pattern, DRE should NOT be performed. Refer to GP	
Performed DRE:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Results:	

This list is not exhaustive and should always be used along side a full clinical assessment and relevant policy and guideline documents.