Continence Screening Form

Document No: _____

To be completed within 48 hours of resident's admission or if there is a change in their continence status.

If the resident is unable to answer these questions, please complete using your observations or by asking a family member or other staff member.

ID LABEL

Date: _____/_____/_____

Bladder Health

1.	Does the resident go to the toilet more than 6 times in the day to pass urine?	☐ Yes ☐ No ☐ Don't know
2.	Does the resident get up more than once during the night to pass urine?	☐ Yes ☐ No ☐ Don't know
3.	Does the resident leak urine?	☐ Yes ☐ No ☐ Don't know
4.	Does the resident have any other bladder problems (ie. difficulties passing urine and/or pain)?	☐ Yes ☐ No ☐ Don't know

Bowel Health

5.	Has the resident lost control of or leaked bowel motions?	☐ Yes ☐ No ☐ Don't know
6.	Does the resident have any other bowel difficulties (ie. constipation or diarrhoea)?	☐ Yes ☐ No ☐ Don't know

Pad Usage

7.	Does the resident wear pads?	☐ Yes ☐ No ☐ Don't know
8.	Does the resident have to change his/her underclothes or wear protection because of bladder or bowel leakage or soiling?	☐ Yes ☐ No ☐ Don't know

If you ticked YES or DON'T KNOW to any of these questions, please:

- **Complete Bladder Chart and Bowel Chart**

Developed by Deakin University and funded under the National Continence Management Strategy