NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

CONTINENCE / TOILETING RISK ASSESSMENT TOOL

TO BE COMPLETED IN BLACK INK

GIG CYMRU NHS WALES

Continence/Toileting Risk Initial Assessment to be completed within 4 hours of admission. A review to be undertaken on each transfer to a Clinical Area/Ward.

If continence / toileting needs are identified the patient must be re-assessed at least **weekly** or sooner if their condition changes and their care plan updated accordingly.

If answered **YES** to **any** questions the patient is at High Risk of becoming incontinent or may already be experiencing incontinence. If risk identified implement an individual **Treatment / Toileting or Management Care Plan.**

Continence status, needs and preferences must be discussed and confirmed at each nursing handover.

At this CURRENT time does your patient:	**Date**	DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY	
	Time	HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM	
Need help to get to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have any cognitive problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have mobility problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to rush to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to use the toilet frequently		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Leak urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Leak faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Have constipation		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have diarrhoea		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bristol stool type															
Have difficulty passing urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have difficulty passing faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally wear a pad or use other devices		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally use a catheter		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Indwelling														
	Intermittent Self Catheterisation														
Normally use any equipment to help with toileting		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Signature															
Designation															

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Have any cognitive problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have mobility problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to rush to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to use the toilet frequently		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Leak urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Leak faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Have constipation		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have diarrhea		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bristol stool type															
Have difficulty passing urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have difficulty passing faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally wear a pad or use other devices		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally use a catheter		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Indwelling														
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