Bowel Assessment

(Please refer to guidelines before completion)

NHS Grampian

1. PATIENT DETAILS	
Name	
Address	
Postcode	Tel No. (incl. STD Code)
D.O.B.	Unit/CHI Number
Occupation	Work Number
Hobbies/Activities	

GP DETAILS	
GP	
Surgery Address	
Tel No. (incl. STD Code)	

CONSULTANT DETAILS	
Consultant	
Address	
Tel No. (incl. STD Code)	

REFERRAL DETAILS	
Referred By	
Tel No. (incl. STD Code)	
Reason for referral	

ASSESSMENT DETAILS	
Assessed By / Date	
Tel No. (incl. STD Code)	
Location of Assessment	

2. FACTORS AFFECTING INDIVIDUALS ABILITY TO COPE: A. M.S.Q. SCORE	

B. DOES PATIENT LIVE:	
Alone:	With Family:
Residential Home:	Nursing Home:
Supported Accommodation:	Other:

C. COMMUNICATION (Please record any problems)		
Speech	Sight	Hearing

D. MANUAL DEXTERITY (Please record any problems)	
Help Required	

ZOY894

E. MOBILITY (Specify help and aids required)	
Independent	

F. USING THE TOILET (Specify help and aids required)	
Can you sit on the toilet?	

G. OTHER AGENCIES INVOLVED

3. PAST MEDICAL HISTORY (please tick if applicable and date if known)			
Neurological Disease		Gynaecological Problems / Surgery	
Diabetes		Rectal Surgery	
Thyroid Disease		Urological Surgery	
Dementia		Urinary Problems	
Cardiac Problems		Other Surgery	
Respiratory Problems		Menopause State	
Depression		Bowel Disease	
Learning Difficulties		Haemorrhoids	
Other		Fissures	

4. ANY SEXUAL HEALTH / LIFESTYLES ISSUES

5. GENERAL CURRENT HEALTH ISSUES

6. OBSTETRIC HISTORY			
Number of Births		Type of Delivery	
Heaviest Weight		Episiotomy / Tear	
Pregnant/ or planning to be		Other comments	

7. MEDICATION	
Medication (incl. over the counter medicines)	Side Effects / Refer To BNF

8. ALLERGIES

9. DESCRIBE YOUR BOWEL PROBLEMS	
What for you is the worst thing about your bowel problem?	
When did the problem start?	
Have you had any investigations?	
What medication has been tried?	
What helps / aggravates the problem?	
Do you use pads or protective clothing?	
Are they effective?	
Has your bowel pattern changed recently?	

10. RESENTING BOWEL SYMPTOMS (* Refer to Management Guidelines)	
	COMMENTS
How often do your bowels move?	
What is the consistency of your stool? (Bristol Stool chart)	(Please circle) 1 2 3 4 5 6 7
* Do you get a desire to open your bowels	
* Are you able to delay?	
How long for?	
* Do you lose control of stool / flatus?	
What quality of stool do you lose control of?	
Do you feel you empty your bowels completely?	
* How long do you sit on the toilet to open your bowels?	
Do you strain?	
* Do you use manual assistance?	
* Do you have any pin or bloating?	
* Do you pass blood or mucus?	

11. INFORMATION FROM BOWEL AND DIET DIARY / FIBRE SCORING SHEET

12. CONSIDER NEED FOR DIGITAL RECTAL EXAMINATION (Refer to RCN Guidelines)	
Consent for Rectal Examination obtained	..... (Nurse Signature)
Outcome of Rectal Examination:	Rectum loaded - YES / No Action:
(Discuss outcome with Doctor)	Stool consistency..... (Bristol Stool Scale)

12b. STOOL SPECIMEN SENT?	
Date Sent:	Result:

12c. FOB TEST CARRIED OUT?

Date:	Result:

13. PROBLEMS IDENTIFIED FROM ASSESSMENT

14. PLAN OF ACTION (see Management Guidelines)

PLEASE TICK SELECTED LITERATURE GIVEN	INFORMATION / LITERATURE GIVEN	REVIEW DATE
Fluid Intake / Dietary advice		
Medication Review		
Information on positioning / environment		
Advice on general exercise		
Stress / Emotional Management		
Aperient Advice		
Bowel Programme / Gastrocolic reflex		
Referral to other Specialist(s)		

15. MANAGEMENT PLAN (see guidelines)

	Product / Type	Per Day	Code No.
Commode			
Pads			
Stretch Fit Pants			
Anal Plugs			
Faecal Collector			

Signature..... Date.....