

**COMMUNITY NURSING BLADDER ASSESSMENT**

Surname: DOB: 0  
First Name: Sex:undefined  
Referred By:

**Presenting Problems:****Medical History:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart conditions     | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Fractures        |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Smoking              | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Falls                | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Kidney Issues    | <input type="checkbox"/> Alcohol              | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Blood Disorder   |

**Other/Details:****Surgical History:****Medications:****Bladder:**

Bladder Diary Maintained: Yes

Bladder Diary Details:

Urine Colour:

Urine Odor: ☐ Offensive**Bladder Dysfunction:**

Stress Incontinence: No sympoms, Leakage Amount: None

Overactive Bladder: No sympoms, Leakage Amount: None

Nocturnal Enuresis: No sympoms, Leakage Amount: None

Overflow Incontinence : No sympoms, Leakage Amount: None

Reflex Incontinence: No sympoms, Leakage Amount: None

Post Micturition Dribbling: , Leakage Amount:

**Toileting Function:****Fluid Balance:**

Fluid Restriction: No

Fluid Restriction Total: 0

Fluid Input (24hrs)		Fluid Output (24hrs)	
Caffeine Drinks:	0 mls	Frequency:	undefined
Alcohol Drinks:	0 mls	Nocturia:	undefined
Other Drinks:	0 mls	Minimum void:	0 mls
IV Fluids:	0 mls	Maximum void:	0 mls
Total:	0 mls	Total:	0 mls

**Mobility:**

Function: Independant

Details:

**Cognitive Function:**

**Hand Function:**

aSAsa

**Environmental Barriers:**

asasas