INCONTINENCE - QUESTIONNAIRE (NIHB QUEBEC REGION)

Client information

Family name: _____ First name(s): _____

Date of birth: _____ Client identification (# band: _____

In order to evaluate this request, please send us the following information:

1) What kind of incontinence :
   - ☐ Urinary
   - ☐ Fecal
   - ☐ Both

2) Primary diagnosis causing this incontinence?
   _____

3) Quantity :

   Day Incontinence
   - ☐ None
   - ☐ Small to moderate
   - ☐ Large or continuous loss of urine
   - ☐ Fecal Incontinence (number of stools/day) : _____

   Night Incontinence
   - ☐ None
   - ☐ Small to moderate
   - ☐ Large or continuous loss of urine
   - ☐ Fecal Incontinence (number of stools/night) : _____

4) Is this problem permanent?
   - ☐ Oui
   - ☐ Non

5) How many diapers and/or hygienic pads are used in 24 hours? _____

6) Does the client :
   - ☐ Work
   - ☐ Goes to school

7) Does the client live at :
   - ☐ Home
   - ☐ In a long term facility home(if yes) which one _____

8) Did the client consult an urologist or gynaecologist?
   - ☐ Yes
   - ☐ No
   - ☐ When is the follow-up ___ _____

9) Has the client's situation worsened since the last request?
   - ☐ Yes
   - ☐ No

Caregiver's name : _____ Date: _____

Signature: _____ Phone: _____

Please fax the information to (514) 283-7762 or toll free 1 855 244-4470

(revised 2021/10)