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# Urinary incontinence Risk Assessment Form

| | | |
|---|---|---|
| **Title:** Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Other: ☐ | **D.o.B.:** _ _ / _ _ / _ _ | **Age:** _____ |
| **Name:** | **Home Address:** | |
| **Surname:** | | |
| **Email:** | **Name & Address of GP** (optional) | |
| **Telephone:** | Would you like your GP to be informed of this consultation? Yes ☐ No ☐ | |

| **Please answer the following questions (must be completed by parent or guardian if under 16)** | |
|---|---|
| Have you had a reaction to antimuscarinics or any other medications before?<br>*If yes, please describe the product and the reaction*<br>Yes ☐ No ☐ | Do you have any allergies?<br>*If yes, please provide details*<br>Yes ☐ No ☐ |
| Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant?<br>Yes ☐ No ☐ | Are you breast feeding?<br>Yes ☐ No ☐ |
| Has your doctor diagnosed you with urge incontinence and/or overactive bladder syndrome?<br>*If you think that you may have a different type of incontinence (e.g., stress incontinence), please list this below*<br>Yes ☐ No ☐ | Do you have gastric retention (problems emptying the contents of the stomach) or any obstructive gastrointestinal disorder?<br>*Your doctor will have told you if you have these*<br>Yes ☐ No ☐ |
| Do you have myasthenia gravis?<br>Yes ☐ No ☐ | Do you suffer from glaucoma (high blood pressure in the eyes)?<br>Yes ☐ No ☐ |
| Do you have any liver or kidney problems?<br>*If yes, please provide details*<br>Yes ☐ No ☐ | Do you suffer from urinary retention (inability to empty your bladder), have difficulties in passing urine or have a poor stream of urine?<br>*If yes, please provide details*<br>Yes ☐ No ☐ |
| Do you have ulcerative colitis or toxic megacolon (acute dilation of the colon caused by infection or inflammation)?<br>Yes ☐ No ☐ | Have you previously received bladder training for your symptoms?<br>Yes ☐ No ☐ |
| Do you suffer from heartburn, indigestion or belching?<br>*If yes, please provide details*<br>Yes ☐ No ☐ | Has your doctor told you that you have an intolerance to any sugars (e.g., galactose intolerance, the Lapp lactase deficiency, glucose-galactose malabsorption fructose intolerance or sucrase-isomaltase insufficiency)?<br>Yes ☐ No ☐ |
| Do you suffer from neurological disorders (e.g., Parkinson's disease, autonomic neuropathy etc.), functional impairment or cognitive impairment?<br>*If yes, please provide details*<br>Yes ☐ No ☐ | Do you have any heart problems or high blood pressure?<br>*If yes, please provide details*<br>Yes ☐ No ☐ |
| Have you noticed blood in your urine, or do you suffer from persistent bladder or urethral pain?<br>Yes ☐ No ☐ | Do you have hyperthyroidism (overactive thyroid)?<br>Yes ☐ No ☐ |
| Do you have abnormally low levels of potassium (hypokalaemia), calcium (hypocalcaemia) or magnesium (hypomagnesaemia) in your blood?<br>Yes ☐ No ☐ | Has your doctor told you that you have hiatus hernia (herniation of an abdominal organ)?<br>Yes ☐ No ☐ |

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| Please answer the following questions (must be completed by parent or guardian if under 16) | |
|---|---|
| Do you have benign prostatic hyperplasia (an enlarged prostate)?<br>Yes ☐ No ☐ | Do you suffer from faecal incontinence?<br>Yes ☐ No ☐ |
| Do you suffer from severe constipation, or do you have a digestive motility disorder?<br>*If yes, please provide details*<br>Yes ☐ No ☐ | Do you think that you may have a urinary tract infection, or do you suffer from recurrent urinary tract infection?<br>*If yes, please provide details*<br>Yes ☐ No ☐ |
| Do you have a pelvic mass?<br>Yes ☐ No ☐ | Do you have intestinal atony (loss of function of the muscles controlling your bowel movements)?<br>Yes ☐ No ☐ |
| **Please list any other symptoms that you experience** | |
| **Please list all your current prescription medication including any medication you buy over the counter** | |
| **Please provide details of any recent or past medical history of note** | |

| Patient consent | |
|---|---|
| I have received information on the risks and benefits of the treatment and I have had the opportunity to ask questions.<br>The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given. | |
| **Signature of patient, parent or guardian** | |
| **Date** | _ _ / _ _ / _ _ _ _ |

| HEALTHCARE PROFESSIONAL USE ONLY | |
|---|---|
| **Non-supply/administration** | |
| **I confirm that the patient did NOT receive the medication** ☐ | **Patient referred to GP** ☐ |
| **Reason for non-supply/administration** | |
| **Supply/administration** | |
| **I confirm that the patient is not contraindicated based on the information provided by the PGD** ☐ | |
| **I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur** ☐ | |
| **I have provided the patient with an information leaflet (PIL) for the treatment I am supplying, and advised them to read it** ☐ | |
| **Healthcare Professional Name** | **Healthcare Professional Signature** |

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|---|---|---|---|---|---|---|
| Appointment | Drug brand, batch number and expiry date | Qty | Price | Date | Patient signature | Pharmacist Signature |
| 1 | | | | | | |
| Comments | | | | | | |
| 2 | | | | | | |
| Comments | | | | | | |
| 3 | | | | | | |
| Comments | | | | | | |
| 4 | | | | | | |
| Comments | | | | | | |
| 5 | | | | | | |
| Comments | | | | | | |