|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Guidance  *This is the referral form to the Leeds Community Services.*  *Section one is compulsory and must be completed.*  *The following sections must be completed as appropriate to the support required.*  *Once this form is completed please email to: lcht.*[*gateway.leeds@nhs.net*](mailto:gateway.leeds@nhs.net) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **COMPULSORY - Section One** | | | | | | | | | | | |
| **Patient Details** | | | Name: |  | Surname: | | | |  | | |
| Gender: |  | DOB: | | | |  | | |
| NHS Number: |  |  | | | | | | |
| Address: |  | | | | | | | |
| **Referrer Details** | | | Name: |  | Designation: | | | |  | | |
| Team: |  | Team Contact Number: | | | |  | | |
| Team Email: |  |  | | | |  | | |
| **GP details** | | | GP Name: |  | Practice address: | | | |  | | |
| **Next of Kin details** | | | Name: |  | Phone Number: | | | |  | | |
| **Admission Details** | | | Not Applicable: (Not a hospital / bed base referral) | | | | | |  | | |
| Consultant  on admission: |  | Current Consultant: | | | |  | | |
| Date of admission: |  | Ward Number: | | | |  | | |
| Expected date of discharge: |  |  | | | |  | | |
| **Reason for referral** Including current and past medical and social history relevant to the referral**:** | | | |  | | | | | | | |
| **Has the patient been considered for Primary Care?** | | | | Yes |  | | No | |  | N/A |  |
| **Is the patient appropriate for consideration for a community bed?** If yes, you may be contacted for further information if required | | | | Yes |  | | No | |  |  | |
| **Visit Request details** | Is a specific date known? | | | Yes  **Complete A** |  | | No  **Complete B** | |  |
| **A** | Date and time of first visit: | | Date: |  | | Time: | |  |
| **B** | Indicative timescale for Visit to be agreed with patient? | | 0-4 hrs |  | | 4-24 hrs | |  |  | |
| Tomorrow  AM |  | | Tomorrow PM | |  |
| Other (Please specify) |  | | | | | | |
| **Does the patient have mental capacity to consent?** | | | | Yes |  | | No | |  |  | |
| **Does the patient give consent?** | | | | Yes |  | | No | |  |  | |
| **Next of Kin / Carers (informal and formal) informed of discharge?** | | | | Yes |  | | No | |  | N/A |  |
| **Is any support required with communication?** | | | | Yes |  | | No | |  |  | |
| If yes, provide details: |  | | | | | | |
| **Are there any safeguarding concerns?** | | | | Yes |  | No | |  | |  | |
| **DNACPR form in place at this point in time:** | | | | Yes |  | No | |  | | Not Known |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COMPULSORY - Section One continued** | | | | | | | | | | | | | | |
| **Property Access:** | Knock and wait | |  | | | Door buzzer | | | | | | | |  |
| Key safe | |  | | | Location and number of key safe: | | | | | | | |  |
| **Referral for Social care only?** | Yes | |  | | | | | | | | | No | |  |
| **No requirement to complete remaining questions** | | | | | | | | | | | **Continue answering questions** | | |
| **Mobility:**  *Select as appropriate* | Independent | |  | | | Supervision | | | |  | | Assistance of 1 | |  |
| Assistance of 2 | |  | | | Walking aid | | | |  | |  | | |
| Additional comments related to mobility:  *(If required)* |  | | | | | | | | | | | | | |
| **Purpose T:**  Pressure risk tool | Green | |  | | | | | Amber | | | | | |  |
| Red | |  | | | | | Not completed | | | | | |  |
| **Skin integrity:** | Intact | |  | | | | | Pressure Ulcer(s) | | | | | |  |
| Wound | |  | | | | | Not checked | | | | | |  |
| **If Pressure Ulcer(s) state category and site:** |  | | | | | | | | | | | | | |
| **Equipment in place at home:** | Profiling Bed |  | | Foam Mattress | | |  | | Air flow mattress | |  | | Pressure relieving cushion |  |
| N/A |  | | Other  (please specify): | | | | |  | | | | | |
| **Equipment ordered and date ordered:** | Equipment Ordered | | | |  | | | | | | | Date Ordered | |  |
| Required for discharge? | | | | | Yes | | | |  | | No | |  |
| **Patient requires support with:**  *Please tick all that apply* | Therapy Needs | | | | | Yes  (go to Section 2) | | | |  | | Not applicable | |  |
| Catheter Care | | | | | Yes  (go to Section 3) | | | |  | | Not applicable | |  |
| Medication | | | | | Yes  (go to Section 4) | | | |  | | Not applicable | |  |
| Wound Management Care | | | | | Yes  (go to Section 5) | | | |  | | Not applicable | |  |
| Intravenous Care | | | | | Yes  (go to Section 6) | | | |  | | Not applicable | |  |
| Enteral Feeding | | | | | Yes  (go to Section 7) | | | |  | | Not applicable | |  |
| Tracheostomy | | | | | Yes  (go to Section 8) | | | |  | | Not applicable | |  |
| Bowel Care | | | | | Yes  (go to Section 9) | | | |  | | Not applicable | |  |

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| *The following sections must be completed as appropriate to the support required.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 2 - Therapy Needs** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Exercise Tolerance** | Stair practice | | | | | | | |  | | | Mobility | | | | | | | | |  | | | | | | | | | | | | Post operation treatment plan | | | | | | | | | | | | |  | | | |
| Fully weight bearing | | | | | | | |  | | | Partial weight bearing | | | | | | | | |  | | | | | | | | | | | | Non weight bearing | | | | | | | | | | | | |  | | | |
| If non or partial weight bearing, is it | | | | | | | | | | | Left | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Right | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Both | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Other requirements:** | Support with activities of daily living | | | | | | | | | | |  | | | | | | | | | | Wash/Dress | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Kitchen assessment | | | | | | | | | | |  | | | | | | | | | | Transfer | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Seating assessment | | | | | | | | | | |  | | | | | | | | | | Wheelchair assessment | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Supplement equipment | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | | |  | | | |
| If yes, explain how | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Next outpatient appointment:** | Insert date: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment provided :** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment ordered:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 3 - Catheter care** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of catheter:** | 1. Urethral | | | | | | | | | | |  | | | | 1. Suprapubic | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| 1. Intermittent | | | | | | | | | | |  | | | | 1. Urostomy | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| 1. Nephrostomy | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Support required:** | Advice/education | | | | | | | | | | |  | | | | Emptying of bag | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Routine change | | | | | | | | | | |  | | | | Site maintenance | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Date of change: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | | | | |
| If yes, explain how | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Supplementary:**  *(If 1 or 2)* | Safe to change in the community? | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | | | | |
| If yes, catheter care management plan sent with patient? | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | | | | |
| Trial without catheter (TWOC) | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | | | | |
| *If yes, insert date if known* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registered with charter | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | | | | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 4 – Support with Medication** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Level of support:** | Administration | | | | | | | | | |  | | | | | | | | | | | | Prompt | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Supervision | | | | | | | | | |  | | | | | | | | | | | | Teaching/Education | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Symptom Management | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of medication:** | Oral from compliance | | | | | | | | | |  | | | | | | | | | | | | Oral from Packets | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Enteral medication | | | | | | | | | |  | | | | | | | | | | | | Transdermal | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Injectable | | | | | | | | | |  | | | | | | | | | | | | Ear/eye drops | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Per rectum/vagina | | | | | | | | | |  | | | | | | | | | | | | Syringe driver | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **If injectable:** | Aranesp | | | | | | | | | |  | | | | | | | | | | | | Vitamin B12 | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Chemotherapy | | | | | | | | | |  | | | | | | | | | | | | Insulin (type) | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Anticoagulant | | | | | | | | | |  | | | | | | | | | | | | Midazolam | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Antiemetic | | | | | | | | | |  | | | | | | | | | | | | Analgesia | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| GCSF | | | | | | | | | |  | | | | | | | | | | | | Hyoscine | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Other: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Frequency:** | Once daily | | | | | | | | | |  | | | | | | | | | | | | | Weekly | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Twice daily | | | | | | | | | |  | | | | | | | | | | | | | Monthly | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Three times daily | | | | | | | | | |  | | | | | | | | | | | | | 12 Weekly | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Four times daily | | | | | | | | | |  | | | | | | | | | | | | | Other: | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | |  | | | | | | | No | | | | |  | | | |
| If yes, explain how | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 5 - Wound Care Management** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of wound:** | Surgical wound | | | | | | | | |  | | | | | | | | | | | | | | | Leg ulcer(s) | | | | | | | | | | | | | | | | | | | | | | |  | |
| Pressure Ulcer(s) | | | | | | | | |  | | | | | | | | | | | | | | | Traumatic | | | | | | | | | | | | | | | | | | | | | | |  | |
| Other(s): | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If surgical, sutures /clips to remove:** | Yes | | | | |  | | | | No | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | |
| If yes, date of removal: | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Dressings required:** | Yes | | | | |  | | | | No | | | | | | | | | | | | | | |  | | | |
| **Dressings with patient**  (7 day supply) **:** | Yes | | | | |  | | | | No | | | | | | | | | | | | | | |  | | | |
| **Frequency of dressings:** | Once daily | | | | | | | | |  | | | | | | | | | | | | | | | Twice a week | | | | | | | | | | | | | | | | | | | | | | |  | |
| Twice daily | | | | | | | | |  | | | | | | | | | | | | | | | Three times a week | | | | | | | | | | | | | | | | | | | | | | |  | |
| Once a week | | | | | | | | |  | | | | | | | | | | | | | | | Fortnightly | | | | | | | | | | | | | | | | | | | | | | |  | |
| Other | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | No | | | | | |  | |
| If yes, explain how | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 6 - Intravenous care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of IV line:** | Hickman | | | |  | | | | | PICC | | | | | | | | | | | | | | |  | | | Portacath | | | | | | | | | | | | | | | | | | |  | | |
| Other: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Line care required:** | Medication Disconnect | | | |  | | | | | Routine Flush | | | | | | | | | | | | | | |  | | | Site Maintenance | | | | | | | | | | | | | | | | | | |  | | |
| **Flushing solutions with the patient:**  (Seven day supply) | Yes | | | |  | | | | | No | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Date Required:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | | No | | | | | | |  | | |
| If yes, explain how | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 7 - Enteral feeding** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of tube feeding:** | Gastrostomy | | |  | | | | | | | | | Jejunostomy | | | | |  | | | | | | | | | | | | | | | | | | | | Nasogastric | | | | | | | | |  | | |
| Naso-jejunal | | |  | | | | | | | | | Other (Please specify): | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Tube care required:** | Connect | | | | | | | | | | | |  | | | | Disconnect | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Flush | | | | | | | | | | | |  | | | | Medications | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Balloon change | | | | | | | | | | | |  | | | | Balloon volume check | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Tube change | | | | | | | | | | | |  | | | | Tube rotation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Advance and rotate | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Frequency:** | Once Daily | | | | | | | | | | | |  | | | | Twice a week | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Twice Daily | | | | | | | | | | | |  | | | | Three times a week | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Three times a day | | | | | | | | | | | |  | | | | Fortnightly | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Four times daily | | | | | | | | | | | |  | | | | Every 12 Weeks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Weekly | | | | | | | | | | | |  | | | | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| **Time of day:** | Day (0700-1700) | | | | | | | | | | | |  | | | | Night (2200-0700) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Evening (1700-2200) | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Level of support:** | Administration | | | | | | | | | | | |  | | | | Prompt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Supervision | | | | | | | | | | | |  | | | | Teaching/Education | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| **Family Support:** | Can Family/Carers support? | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | |  | | | | | | | | No | | | |  | | |
| If yes, explain how | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Regime to be sent with patient** | Yes | | | |  | | | | | | | | No | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Equipment sent** | Yes | | | |  | | | | | | | | No | | | | | |  | | | | | | | | | |
| **Referral made to Enteral feeding homecare company nurse** | Yes | | | |  | | | | | | | | No | | | | | |  | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | |  | |
| **Additional information:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 8 - Tracheostomy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Level of support:** | | Administration | | | | | | | | | | | |  | | | | | | Prompt | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Supervision | | | | | | | | | | | |  | | | | | | Teaching/Education | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Family carer able to support?** | | Yes | | | | |  | | | | | | | No | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Level of independence of patient** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment in place** | | Yes | | | | |  | | | | | | | No | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Equipment sent with patient** | | Yes | | | | |  | | | | | | | No | | | | | |  | | | | | | | | | |
| **Family Support:** | | Can Family/Carers support? | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | | | | | | | |  | | | | | | | No | | | | |  |
| If yes, explain how | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 9 – Bowel Care** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of Bowel care** | | Enema - Microlax | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Enema - Phosphate | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Enema - Other  (Please specify): | | | | | | | | | | | |  | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Suppository | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Manual/Digital Evacuation | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Bowel Irrigation | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| Specify details | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Frequency Required** | | Detail frequency | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication / Equipment** | | With patient? | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| **Family Support:** | | Can Family/Carers support? | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | | |  | | | | | | | | | | | | | No | | | | |  |
| If yes, explain how | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional information:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |