

## PROGRESS NOTE - CONTINENCE CLINIC

<b>Name:</b>	<b>PARIS ID:</b>
<b>DOB:</b>	<b>PHN:</b>
<b>Gender:</b>	<b>Phone:</b>
<b>Home Address:</b>	

**Casenote Date:**                      **Reason:**                      **Staff Member:**

### Next Planned Contact/Visit

Planned Date:

Contact Type:                      Reason:

Planned Staff:

### Today's Contact Information for MRR

Contact #1                      Service Delivery Setting:

Contact Type:    ☐ Face to Face Visit                      Duration:                      hr                      Min

☐ Telephone Call in lieu of Face to Face

Contact #2                      Service Delivery Setting:

Contact Type:    ☐ Face to Face Visit                      Duration:                      hr                      Min

☐ Telephone Call in lieu of Face to Face

Contact #3                      Service Delivery Setting:

Contact Type:    ☐ Face to Face Visit                      Duration:                      hr                      Min

☐ Telephone Call in lieu of Face to Face

Contact #4                      Service Delivery Setting:

Contact Type:    ☐ Face to Face Visit                      Duration:                      hr                      Min

☐ Telephone Call in lieu of Face to Face

### Treatment-Continence Clinic

- |  |   |
|--|---|
| <input type="checkbox"/> Kegel Pelvic Floor Exercises                | <input type="checkbox"/> Bedside Commode/Urinal                                 |
| <input type="checkbox"/> Bladder Training                            | <input type="checkbox"/> Caregiver Instruction                                  |
| <input type="checkbox"/> Urge Suppression                            | <input type="checkbox"/> Personal Hygiene                                       |
| <input type="checkbox"/> Voiding Diary                               | <input type="checkbox"/> Bowel Hygiene  |
| <input type="checkbox"/> Prompted Voiding                            | <input type="checkbox"/> Change Dietary Fibre                                   |
| <input type="checkbox"/> Fluid Intake Changes                        | <input type="checkbox"/> Incontinence Product Education (disposable/reusable)   |
| <input type="checkbox"/> Caffeine Reduction                          | <input type="checkbox"/> Education re: bladder structure and function           |
| <input type="checkbox"/> Intermittent Catheterization Self/Caregiver | <input type="checkbox"/> Education booklet given (Turning Off.../Coming Out...) |
| <input type="checkbox"/> Functional Changes                          | <input type="checkbox"/> Recommend Estrogen/lubricant cream                     |
| <input type="checkbox"/> Referral to:                                |   |
| <input type="checkbox"/> Samples given to:                           |   |

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Name:	PARIS ID:
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**Needs**

Need	Post to C/P	Processed	Comments
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**Casenotes**

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----