

NWSIC Bowel Management Chart

Name..... Hospital No..... DOB..... Level.....

Assessor..... Date..... REFLEX/FLACCID (Please circle)

Aperient:..... Frequency:..... Stimulant:.....

APERIENT			Date/ Time	Consent	DRS	Rectal Stimulant	U.T.T	Reflex Spont Type	Man/ Evac Type	Time Taken	Initials	UNPLANNED	Time	Chair/Bed	Type/Amount	Reported to RN			
Date	Time	Medication																	
Comments:																			
Comments:																			
Comments:																			
Comments:																			

Reviewed by R/N..... Date.....

Any Changes.....
 *DRS = Digital Rectal Stimulation U.T.T = Up To Toilet

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