CHERRYVALE CARE CENTER **3 DAY BLADDER STUDY**

Resident ______ DATE: ____________

This assessment will be done to evaluate the bladder habits of our residents. This assessment will be done for all new admissions

Make sure you fill out all for all shifts and fill out all blanks.

	Time Interval	Urinated in toilet	Had a small incontinence episode	Had a large incontinence episode	Reason for incontinence episode	Type/amount of liquid intake	CNA SIGN
6a.m. to 2p.m.	6–8 a.m.						
	8–10 a.m.						
	10–noon						
	Noon–2 p.m.						
2p.m. to 10p.m.	–4 p.m.						
	4–6 p.m.						
	6–8 p.m.						
	8–10 p.m.						
	Final bed Check						
10p.m. to 6a.m.	10pm-MN						
	MN -2am						
	2am-4am						
	Final bed Check						

Any time the resident verbalizes the need to toilet indicate that with a *

Kathy will collect Bladder Records daily. Please make sure you have completed and signed this sheet.

05/21/2002