Cauda Equina
Spinal Cord Injury

Coloplast

Bowel and Bladder Health Check

Bowel and bladder issues are two of the biggest worries for many people living with Cauda Equina. We understand you may develop problems with either your bowel or bladder that might stop you doing the things you want to do.

You don't need to put up with bowel and bladder problems because simple things can make a difference.

Just take a few minutes to complete this questionnaire, save it and email it to coloplastnursinguk@coloplast.com

Name _____ Surname _____

Address _____

Post code _____

Email _____

Tel No. _____ Date of birth ___/___/___

Your details: Gender: ◯ Male ◯ Female Age range: ◯ 18-24 ◯ 25-34 ◯ 35-50 ◯ 51-64 ◯ 65+

Date of your Cauda Equina diagnosis: _____

I am happy for Coloplast to contact me using the above information: ◯ Accept ◯ Reject

By providing your personal and sensitive data, you are consenting to Coloplast Limited that we may process and store your data for the purposes to fulfil your sample request, to keep you informed about it and follow-up via phone, text, email, or post, and to improve our products and services. We may refer you to healthcare professionals if needed. We may share your data with our sub-vendors when necessary to fulfil the request and transfer data securely outside the EU to support our business operations. You may withdraw consent at any time without ramifications, by writing to privacyrequests@coloplast.com or calling us at 0800 132 787.

For more information, please visit our privacy policy for consent: Privacy Policy UK - Coloplast UK

Bowel Health Check[1] NBDS

1. Your bowel routine

How do you empty your ***bowels***? Please tick all that apply

- ◯ I move my bowels easily with no intervention
- ◯ Irrigation (flush, rectal or transanal)
- ◯ Other (please specify)
- ◯ Enemas
- ◯ Oral laxatives
- ◯ Suppositories
- ◯ Herbal remedies

	Score
2. How often do you open your bowels? ◯ Daily (score 0) ◯ 2–6 times per week (score 1) ◯ Less than once per week (score 6)	
3. How much time do you spend on opening your bowels? ◯ Less than 30 min. (score 0) ◯ 31–60 min. (score 3) ◯ More than an hour (score 7)	
4. Do you experience uneasiness, sweating or headaches during or after opening your bowels? ◯ Yes (score 2) ◯ No (score 0)	
5. Do you take medication (tablets) **to treat constipation?** ◯ Yes (score 2) ◯ No (score 0)	
6. Do you take medication (drops or liquid) **to treat constipation?** ◯ Yes (score 2) ◯ No (score 0)	
7. How often do you use digital (finger) **evacuation to have a bowel movement?** ◯ Less than once per week (score 0) ◯ Once or more per week (score 6)	
8. How often do you have involuntary defaecation / are incontinent of faeces? ◯ Daily (score 13) ◯ 1–6 times a week (score 7) ◯ 1–4 times a month (score 6) ◯ A few times a year or less (score 0)	
9. Do you take medication to treat faecal incontinence? ◯ Yes (score 4) ◯ No (score 0)	
10. Do you experience uncontrollable flatus / wind? ◯ Yes (score 2) ◯ No (score 0)	
11. Do you have problems with the skin around your anus? ◯ Yes (score 3) ◯ No (score 0)	
Total score (between 0 and 47)	

General satisfaction: Please mark the scale with a cross (x) to represent your general satisfaction with your bowel management. (Total dissatisfaction = 0 / Perfect satisfaction = 10)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Severity of bowel dysfunction

Score 0-6:	Very minor
Score 7-9:	Minor
Score 10-13:	Moderate
Score 14+:	Severe

1. Bowel Health Check - adapted from Krogh K, Christensen P, Sabroe S, Laurberg S. Neurogenic bowel dysfunction score. Spinal Cord 2006; 44:625–631
2. Bladder Health Check - adapted from Burks J, Chancellor M, Bates D, Denys P, DeRidder D, MacDiarmid S, et al. Development and Validation of the Actionable Multiple Sclerosis Bladder Health Screening Tool, International Journal of MS Care, 2013, Winter 15(4):182-92.

Bladder Health Check[2]

1. Your bladder routine

How do you empty your *bladder*? Please tick all that apply

- ◯ I self-void (I pass urine without intervention)
- ◯ I use an intermittent catheter (ISC)
- ◯ I wear a urinary sheath
- ◯ I have a suprapubic catheter
- ◯ I have an indwelling urethral catheter
- ◯ Other (please specify)

Have you received a bladder scan? ◯ Yes ◯ No If **yes,** please state when (date):

2. Your bladder symptoms and impact

For the following questions, please tick the response which best describes your bladder symptoms over the ***past 4 weeks***:

During the day, how strong was the feeling that you needed to urinate right away?	◯ Not at all strong	◯ A little strong	◯ Moderately strong	◯ Extremely strong
How often do you feel you have the urge to go again after you finished urinating?	◯ None of the time	◯ Some of the time	◯ Most of the time	◯ All of the time
How often have you had urinary accidents/leakage?	◯ None of the time	◯ Some of the time	◯ Most of the time	◯ All of the time
On a typical night, how often did you wake up in the night to urinate?	◯ None of the time	◯ 1 time	◯ 2 times	◯ 3 or more times
On a typical day, how many times did you urinate?	◯ 0-3 times	◯ 4-6 times	◯ 7-11 times	◯ 12 or more times
How would you describe your usual urination?	◯ Normal	◯ Need to push with muscles or change position	◯ Need to press with hands	
How would you describe your urine flow?	◯ Normal	◯ Weak	◯ Drop by drop	
In general, how has your urination been?	◯ Normal and quick	◯ Difficult to start or easy at first but slow finish	◯ Very slow start to finish	

For the following questions, please tick the response which best describes impacts from bladder symptoms you may have experienced over the ***past 4 weeks***:

How much have your activities with friends and family been limited by your bladder problems?	◯ Not at all	◯ A little	◯ Moderately	◯ Extremely
How embarrassed have you been because of your bladder symptoms?	◯ Not at all	◯ A little	◯ Moderately	◯ Extremely
How much has your ability to work (paid / volunteer) outside home been limited by your bladder problems?	◯ N/A or Not at all	◯ A little	◯ Moderately	◯ Extremely

For the following question, please tick the response which best describes your bladder symptoms over the ***past 6 months***:

How many UTIs have you had in the past 6 months?	◯ None	◯ 1 UTI	◯ 2 UTIs	◯ 3 or more

Bladder symptoms and impact score: *Please add the number of responses ticked from the columns in the shaded blue area relating to your bladder symptoms and impact*

[ ] + [ ]

Total no. of ticks: [ ]

3. Your bladder equipment and routine

Are you experiencing any issues with your bladder equipment and routine? ◯ Yes ◯ No

General satisfaction: Please mark the scale with a cross (x) to represent your general satisfaction with your bladder management

(Total dissatisfaction = 0 / Perfect satisfaction = 10)

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

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