Shropshire Community Health NHS
NHS Trust

CNT 039 Request Form for Off Formulary Products

First Name	Surname
D.O.B	NHS No:
Address: Postcode	
Current Products	
Details of problem	
Reassessment Attached Yes / No	***Delete as appropriate***

Please read each question and complete in as much details as possible	
Is the patient diabetic?	Yes / No Type 1 / Type 2
Does the patient take a diuretic?	Yes / No
If yes name and dosage?	
Does the Patient use "all in one" style pads	Yes / No
If YES, please state their current waist size in CMs	
(if unsure please check with family / carer etc)	
Have you gone through the fitting guide with them	Yes / No
Is the patient in shaped pads	Yes / No
If Yes have you explained how to use net pants or close fitting pants correctly to secure, comfortable fits?	Yes / No
Have you gone through the fitting guide with them?	Yes / No
Comments	

Have you explained how to check the wetness indicator before changing the pad? And that it can be ¾ wet before next change	Yes / No
Comments:	

		Comment:
How long are they in bed between care inputs?		
How many times are they toileted? Or if not at all?		
Have you discussed with the patient / carer that they can micturate more than once in one pad **Yes / No**		
Does the patient use barrier cream? **Yes / No** If yes name? …….. have you discussed how to apply the cream while wearing pads Yes / No		
Does the patient use talc **Yes / No** If yes have you advised to avoid using talc while wearing a pad **Yes / No**		
Please delete as appropriate		
Urinary Incontinence	Faecal Incontinence	Urinary & Faecal Incontinence

What is the patients fluid intake & output - please enclose "Bladder Diary"	
Fluid Intake:	Urinary frequency / voided volumes

Staff Name (print)	**Signature:**	
Base	**Contact No:**	**Job Title**
Please sign to say you have addressed all of the above issues before posting / faxing to your area Continence Advisor		

Continence Advisor Comments	
Continence Advisor name:	Signature: