

Application for Continence Aids

What is required in a Continence Assessment to MASS for a New Client

1. A continence assessment template that a community or hospital has designed which includes the below information:
 - **Types of incontinence UI** (Urinary incontinence or FI (Faecal incontinence) or Both / Type of bladder or bowel dysfunction.
 - **Medical conditions** including ones that impact on continence status. Evidence in your assessment the client has a condition that is stabilised and long-term.
 - Associated **functional issues** a client has that is impacting on incontinence.
 - How client **manages during the day and night** including information on any issues with Nocturia, urgency or history of falls/falls risk.
 - **Medication** that may be impacting on the bladder or bowel dysfunction.
 - **How long a client has had incontinence** or bladder dysfunction (If needing a long-term catheter or using disposable catheter).
 - How the client is **currently managing continence needs** and advise on strategies you have given the client on management of current continence needs.
 - Information on **referrals client has been given** or confirmation client is wanting conservative management.
 - Information on the **trial of aids** with the client.
 - If client is under 65 years of age, please include evidence of the continence condition being a medical condition only and evidence the client does not have any NDIS eligible conditions.
2. A Word or PDF document that has been attended by a prescriber which has the above information.
3. A GP Careplan that has the above information.



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**Queensland
Government**