









Client Name:









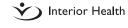
ESTABLISHED OSTOMY ASSESSMENT FLOWSHEET & MANAGEMENT PLAN Community Care

Established: at least 8 weeks post-surgery. Please fill out ONE form per Ostomy or Mucous Fistula.

OSTOMY ASSESSMENT - ON ADMISSION																
		(to be r	eassessed	if chan	ge in os	tomy c	ondition)								
Year of Surgery:									0 =	O = Ostomy MF = Mucous Fistula						
Ostomy Type: Ilea	ostomy 🗌 Co	olostomy 🗌 Ur	ostomy [Mucc	ous Fist	ula 🗌	Other _		-		ЛI					
Ostomy Construction	n: 🗌 End 📗	☐ Loop ☐ Do	ouble Barr	el						16	CM					
Stoma Shape/Size:	Round (mm) 🗆 🤆	Oval	(L	x W in	mm)										
Stoma Os: Center	red 🗌 Off-	centered	Tilted								ш					
Stoma Height: 🗌 Ra	nised 🗌 Flus	sh 🔲 Retracte	ed 🗌 F	Prolapse	ed grea	er than	2cm		Not	es:						
Date: Signature:																
		OSTOM	Y ASSE	SSME	NT –	ONG	OING									
Legend: Blank Space	Legend: Blank Space = Not Assessed (as per agency) ✓= Assessed/Completed NN = See Narrative Notes N/A = Not Applicable															
Assessment to be done with	Year	Month/Day														
pouch change		Time														
Pouching System Change	Routine															
	Leakage us	se clock to indicate where														
Stoma Appearance		Pink/red & moist														
	Other															
Peristomal Skin	Intact															
	Erythema															
Excoriated (E)	Indurated															
Superficial skin loss	Excoriated	I / Denuded														
Denuded (D): Partial thickness skin loss	Macerated	l														
MARSI = Medical Adhesiv	MARSI															
Related Skin Injury	Bruised															
	Wound															
	Rash															
	Other	Other														
Bowel Output N/A	Ostomy pr	oducing? Y/N														
Characteristics Chart all output on In/Out Flow Sheet (if required).	Watery/Mu	shy														
	Semi-form	ed														
Colour Legend: Yellow = Y	Formed															
Green = G Clay = C Black= Bk	Hard															
Bloody = Bd	Colour (see	e legend)														
	Other															



















ESTABLISHED OSTOMY ASSESSMENT FLOWSHEET & MANAGEMENT PLAN Community Care

Client N	lame:		
DOB:			
PHN:			

OR ADDRESSOGRAPH/LABEL

U Juici.													
☐ Urine Collection System: ☐ Leg Bag ☐ 2L Bag ☐ Bottle☐ Other:													
	- I og Rog □ 2l Rog □ Ro												
☐ Adhesive Remover		— [
☐ Barrier Ring													
□ Pouch		- [
□ Flange]											
☐ Pharmacy/Retail Store_													
☐ Health Authority Orderin	g System												
Supplies (add Vendor Nan	•		ouch Ch	ange So	enedule_			266	MOMOC	Note a	s or date		
Supplies (add Vendor Name/Order Number if known) Supplies (add Vendor Name/Order Number if known) Pouch Change Schedule See NSWOC Note as of date													
										(indicate Os	stomy or Mu	cous Fistula)	
	Signature:												
Occupational Therapy		Social Work Date: Signature:											
NSWOC Date:		Dietitian Date:						Signature:					
			REI	FERRA									
	Initials												
If Ot													
See N													
See NSWOC Notes													
Change don	e as per Management Plan												
Pain (with pouch change)	On scale of 0-10 out of 10												
	Other												
	Colour (see legend)												
Red = R	Malodourous (foul smelling)												
Orange = O Pink = P	Sediment												
Yellow = Y Amber = A	Clots												
Colour Legend: Pale Yellow =PY	Cloudy												
Characteristics Chart amount on In/Out FlowSheet (if required)	Mucous Shreds												
	Concentrated												
Urine Output N/A	Clear												