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Client Name:

ESTABLISHED OSTOMY ASSESSMENT FLOWSHEET & MANAGEMENT PLAN
Acute Care

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

OSTOMY ASSESSMENT - ON ADMISSION

(to be reassessed if change in ostomy condition)

Year of Surgery: _____

Ostomy Type: ☐ Ileostomy ☐ Colostomy ☐ Urostomy ☐ Mucous Fistula ☐ Other _____

Ostomy Construction: ☐ End ☐ Loop ☐ Double Barrel

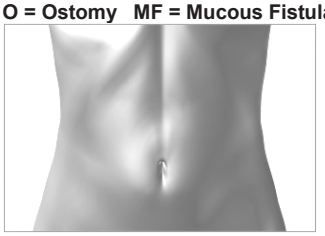
Stoma Shape/Size: ☐ Round (mm) _____ ☐ Oval_____(L x W in mm)

Stoma Os: ☐ Centered ☐ Off-centered ☐ Tilted

Stoma Height: ☐ Raised ☐ Flush ☐ Retracted ☐ Prolapsed greater than 2cm

Date: _____ **Signature**: _____

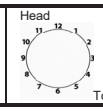
O = Ostomy MF = Mucous Fistula



Notes:

OSTOMY ASSESSMENT - ONGOING

Legend: Blank Space **=** Not Assessed (as per agency) ✓**=** Assessed/Completed **NN =** See Narrative Notes **N/A** = Not Applicable

Assessment to be done with pouch change	**Year** / **Month/Day** / **Time**											
Pouching System Change 	Routine											
	Leakage use clock to indicate where											
Stoma Appearance	Pink/red & moist											
	Other											
Peristomal Skin	Healthy & intact											
	Other											
Bowel Output N/A ☐ Characteristics Chart all output on In/Out Flow Sheet (if required). Colour Legend: Yellow=Y Brown=B Green=G	Ostomy producing? **Y/N**											
	Mucousy											
	Watery/Mushy											
	Semi-formed/Formed											
	Colour (see legend)											
	Other											
Urine Output N/A ☐ Characteristics Chart amount on In/Out FlowSheet (if required) Colour Legend: Pale Yellow=PY Yellow=Y	Clear											
	Concentrated											
	Mucous Shreds											
	Colour (see legend)											
	Other											
Pain (with pouch change)	On scale of 0-10 out of 10											
Change done as per Management Plan												
See Narrative Notes for concerns												
If concerns noted, refer to NSWOC												
Initials												

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ESTABLISHED OSTOMY ASSESSMENT FLOWSHEET & MANAGEMENT PLAN
Acute Care

Client Name: _____

DOB: _____

PHN: _____

OR ADDRESSOGRAPH/LABEL

REFERRALS

NSWOC Date Signature	**Dietitian** Date Signature
Home/Community Care Date Signature	**Social Work** Date Signature

MANAGEMENT PLAN for _____ (indicate Ostomy or Mucous Fistula)

☐ **Self-Care** ☐ **Partial Assistance** ☐ **Full Care**

Supplies add Vendor Name/Order Number (if known)

- ☐ Health Authority Ordering System
- ☐ Pharmacy/Retail Store_____
- ☐ Flange_____
- ☐ Pouch _____
- ☐ Barrier Ring: _____
- ☐ Adhesive Remover _____
- ☐ Ostomy Belt_____
- ☐ Urine Collection System ☐ Leg Bag ☐ 2L Bag ☐ Bottle
- ☐ Other:

Pouch Change Schedule_____ **See NSWOC Note as of date** _____

Date **Signature**

MANAGEMENT PLAN for _____ (indicate Ostomy or Mucous Fistula)

☐ **Self-Care** ☐ **Partial Assistance** ☐ **Full Care**

Supplies add Vendor Name/Order Number (if known)

- ☐ Health Authority Ordering System
- ☐ Pharmacy/Retail Store_____
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- ☐ Adhesive Remover _____
- ☐ Ostomy Belt_____
- ☐ Urine Collection System ☐ Leg Bag ☐ 2L Bag ☐ Bottle
- ☐ Other:

Pouch Change Schedule _____ **See NSWOC Note as of date** _____

Date **Signature**