

Pre- & Post-Operative Ostomy Assessment Patient Teaching & Transition of Care	Client Information
Patient accompanied by: _____ Patient's preferred language: _____ Translator present: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Stoma Marking Only <input type="checkbox"/> Reason: _____ Hernia risk noted: <input type="checkbox"/> Yes <input type="checkbox"/> No Communication to OR team done: <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Surgery Diagnosis: _____ Surgeon: _____ OR Date: _____ Ostomy: <input type="checkbox"/> Potential <input type="checkbox"/> Emergent <input type="checkbox"/> Planned Anticipated Surgical Procedure: _____ Anticipated Outcome: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Unknown	
Medical/Surgical History related to ostomy surgery Medical history: _____ _____ Previous surgical history: _____ _____	
Self Care Assessment Occupation: _____ Support Person (name/relationship): _____ Patient has concerns with the following: <input type="checkbox"/> N/A <input type="checkbox"/> Cognition <input type="checkbox"/> Mental health <input type="checkbox"/> Hand dexterity <input type="checkbox"/> Mobility <input type="checkbox"/> Hearing <input type="checkbox"/> Seeing <input type="checkbox"/> Other concerns: _____ If noted, comment: _____	
Living Amenities: <input type="checkbox"/> Housing/Shelter <input type="checkbox"/> Electricity <input type="checkbox"/> Running water <input type="checkbox"/> Phone <input type="checkbox"/> Internet <input type="checkbox"/> Means of transportation	
Pre-Op Patient Teaching <input type="checkbox"/> Patient declined <input type="checkbox"/> Partial info provided only	
<input type="checkbox"/> Patient/family's understanding of the diagnosis and why surgery is needed	Surgical procedure: <input type="checkbox"/> Stoma appearance <input type="checkbox"/> Stent (urostomy only) <input type="checkbox"/> Loop with/without rod <input type="checkbox"/> Rectal discharge if applicable
Diet: <input type="checkbox"/> Urostomy <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy <input type="checkbox"/> Week 1 to 6 post-surgery <input type="checkbox"/> 7 weeks and greater For Ileostomy: <input type="checkbox"/> Dehydration <input type="checkbox"/> Food blockage	Pouching Systems: if applicable to patient <input type="checkbox"/> Components (1-pce and/or 2pce) <input type="checkbox"/> Accessories <input type="checkbox"/> Pouch application demonstration <input type="checkbox"/> Characteristics of effluent over time <input type="checkbox"/> Frequency of pouch emptying <input type="checkbox"/> How to empty the pouch <input type="checkbox"/> fecal <input type="checkbox"/> urine <input type="checkbox"/> Cleansing urocare bottles/drainage bags*
ADLs: <input type="checkbox"/> Strategies for odour control <input type="checkbox"/> Clothing <input type="checkbox"/> Showering/swimming <input type="checkbox"/> Sexual function <input type="checkbox"/> Exercises following abdominal surgery*	
Ostomy education resources provided: <input type="checkbox"/> Video <input type="checkbox"/> Booklet <input type="checkbox"/> Other: _____	
Comment: _____	

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*Client Health Education Resource available

Insurance Coverage: ☐ Unknown at this time

PharmaCare coverage: ☐ Fair PharmaCare ☐ Plan B (LTC) ☐ Plan W (FN)

Extended Health Benefits: ☐ Yes ☐ No

Stoma Marking: ☐ New ostomy ☐ Re-siting

Assessed in the following positions: ☐ Supine ☐ Standing ☐ Sitting ☐ Bending ☐ Other _____

☐ Wheelchair bound

Marked stoma location(s):

☐ RUQ ☐ LUQ ☐ RLQ ☐ LLQ ☐ Other _____

☐ Within rectus muscle

☐ Within person's visual field

☐ Away from scars/creases/folds

☐ Belt Line: ☐ On ☐ Above ☐ Below

Concerns/Comments/Special Considerations:



Pre-Op Hernia Assessment ☐ At risk ☐ No risk

Existing hernia ☐ Yes ☐ No If yes, type: _____ ☐ Hx of any hernia repair

Age: ☐ greater than 70 ☐ Between 5-15 Malnutrition noted: ☐ Yes ☐ No ☐ Unknown

BMI greater than 30: ☐ Yes ☐ No If yes: BMI _____ Girth greater than 100cm: ☐ Yes ☐ No If yes _____ cm

Health concerns: ☐ Diabetes ☐ Advanced cancer ☐ Liver damage ☐ Chronic constipation ☐ Smoking
☐ Abdominal Aortic Aneurysm

Occupational, lifestyle or ADL risk of lifting 4.5kgs or greater: ☐ Yes ☐ No if Yes, what is the risk _____

Medications: ☐ Steroids ☐ Chemo

Date: _____ **Signature:** _____

Post-Op Hernia Risk Assessment

Type of colostomy: ☐ Ascending ☐ Transverse ☐ Descending ☐ Sigmoid

Procedure: ☐ Loop ☐ End Emergency surgery: ☐ Yes ☐ No

Stoma outside rectus abdominis muscle: ☐ Yes ☐ No Fascial trephine aperture: ☐ 25-33mm ☐ Greater than 34mm

Post-op wound infection: ☐ Yes ☐ No

Patient at risk for hernia development (pre & post pre surgery risk factors): ☐ Yes ☐ No

Patient teaching done ☐ Comments:

Date: _____ **Signature:** _____

Transition of Care

Ostomy Supplies required:

Flange: _____ Pouch: _____ Accessories: _____

Delivery time of pharmacy/supply store** selected by patient: _____ Hospital supply needed: ☐ Yes ☐ No

Vendor discharge program information provided: ☐ Yes

Receiving NSWOC notified: ☐ Yes Site: _____

Date: _____ **Signature:** _____